State of Tennessee
Department of Finance and Administration
Division of Health Care Finance and Administration
Bureau of TennCare

TennCare Medicaid EHR Provider Incentive Program

Provider Incentive Payment Program (PIPP) Portal User Manual

Version No. 4.0

Presented by:

MAXIMUS
Government Health Consulting

February 12, 2016

Revision History

Revision Date	Version No.	Updated By	Description of Revision
11/01/2011	*1.0*	*TStanfill*	*Final Version*
11/23/2011	*1.1*	*TStanfill*	*Update Password Reset Instructions*
6/5/2012	*2.0*	*BGrafals*	*Updated with Meaningful Use Information*
6/15/2012	*2.1*	*BGrafals*	*Incorporated comments from Provider Services*
6/22/2012	*2.2*	*BGrafals*	*Incorporated comments from Provider Services and Quality*
6/25/2012	*2.3*	*BGrafals*	*Minor format changes*

TennCare Approval Review

This document has been reviewed by the following people:

Reviewer Name	Date	Version No.	Revision Remarks
D.Stockett	*02/26/13*	*3.0*	*Significant Revisions, Impacts from the Stage 2 Final Rule; PIPP Portal changes made*
D.Stockett	*02/08/16*	*4.0*	*Significant Changes made as the result of the Stage 3 & Modifications to MU 2015-2017 enacted by CMS 2015*

Table of Contents

Table of Figures

Table

1. Preface

This Provider Incentive Payment Program (PIPP) portal user manual is intended to provide Eligible Professionals (EPs) and Eligible Hospitals (EHs) guidelines for successfully navigating the TennCare Medicaid Electronic Health Record (EHR) Provider Incentive Payment Program enrollment and attestation system.

The TennCare Medicaid EHR Provider Incentive Payment Program (PIPP) is for providers who are eligible for the Medicaid EHR incentive payments outlined in the American Recovery and Reinvestment Act (ARRA) of 2009, and serve the TennCare Medicaid population as well as needy individuals in the State of Tennessee who qualify for services through an FQHC or RHC. EPs and EHs use this portal to attest to adoption, implementation or upgrading (AIU) (Payment Year 1) of a certified Electronic Health Record system. EPs and EHs will also use this portal to attest and prove Meaningful Use (MU) (Payment Years 2 through 6 (EPs) or Years 2 & 3 (EHs)).

TennCare is providing this material as a reference to providers. TennCare will make every reasonable effort to ensure this material is accurate and up-to-date; however, it is ultimately the responsibility of the providers to ensure they are submitting the required information in order to receive EHR incentive payments.

Complete definitions and rules can be found in the

- ARRA (the HITECH Act)
- Title XIX of the Social Security Act
- 42 CFR Parts 412, 413, 422 and 495, Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule (75 FR 44314); as updated by CMS
- 42 CFR Parts 412, 413, and 495, Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2 (77 FR 53968); as updated by CMS.

This guide is not to be used in lieu of the Final Rules or any above-mentioned Acts for guidelines in qualifying and obtaining the EHR incentive payments. This manual should be treated as an additional resource. Please refer to the above-mentioned Acts and the Final Rules for clarifications.

If at any time you have a question, please check our website first. If you still need assistance, send an email to TennCare.EHRIncentive@tn.gov for all questions regarding PIPP Portal Registration and the sections of the attestation labeled Provider Questions, EHR Questions, Required Forms, and Patient Volume, or general questions about the EHR Incentive Program.

E-mail EHRMeaningfulUse.TennCare@tn.gov for all questions regarding the Meaningful Use Objectives or Clinical Quality Measures.

A TennCare staff member will respond to your inquiry.

1.1 Who is eligible to participate in the EHR Incentive Program

The determination as to which providers are eligible to participate are stated in the *Code of Federal Regulations (CFR)* 42 CFR 495.304(a) & (b).

- Eligible Professionals (EPs) include
    - Physicians (both Medical and Osteopathic)
    - Nurse Practitioners (aka Advance Practice Nurses)
    - Certified Nurse Midwives
    - Dentists
    - Physician Assistants (PAs) when practicing in a Federally Qualified Health Center (FQHC) when led by a PA, or in a Rural Health Center(RHC) when so led by a PA. (See our FAQs for further information.)
- Eligible Hospitals (EHs) include
    - Acute Care Hospitals – whose average length of stay is less than 25 days
    - Critical Access Hospitals (CAHs)
    - Children's Hospitals

2. Eligible Professional & Eligible Hospital User Accounts

Prior to gaining access to the TennCare PIPP portal, EHR provider registration must be completed at the CMS Registration and Attestation System (R&A) website. Once TennCare has received a notice of successful EHR registration, providers will be sent an invitation to create a user name and password for the TennCare PIPP portal via the email address listed in the CMS R&A System.

Note about email addresses: Some providers use consultants to assist them in the process of registering and attesting in the EHR Incentive Program. TennCare has no objection to the use of consultants. Providers should be aware however, that sometimes consultants enter **their** own email address rather than that of the provider. As all of our communications are done via email, including a monthly e-newsletter, and on occasions, direct intervention may be needed by respective provider, these email communications will be going to the consultant rather than the provider. It is in the provider's best interest to either stay in close contact with the consultant, or insist on the provider's email address be used.

2.1 Log In Setup

Upon receipt of the email invitation to create an account for the TennCare PIPP portal, go to https://pipp.tenncare.tn.gov/Default.aspx to create a User Name and Password. The link is also provided in the email.

2.1.1 Access Provider Web Registration

Click on the 'Provider Web Registration' (red arrow) link on the left side of the Log In screen. (Figure 1) Unless we tell you otherwise, you will only access this link one time for each provider participating in the EHR Incentive Program. After you have established a User Account, you will only need to click on "Log In" (blue arrow), and enter your User Name and Password. (Figure 2)

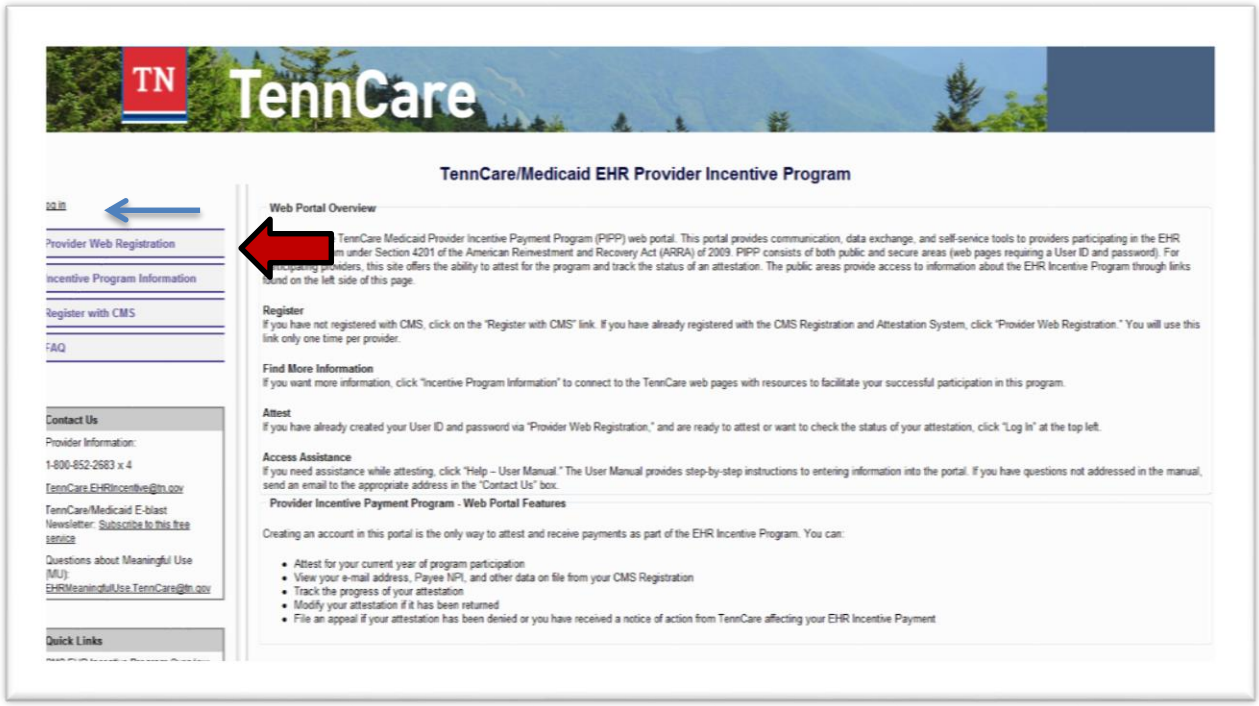


Figure 1 - Home Screen

After you have established a User Account, click on "Log in" (blue arrow above), which will bring up this page.

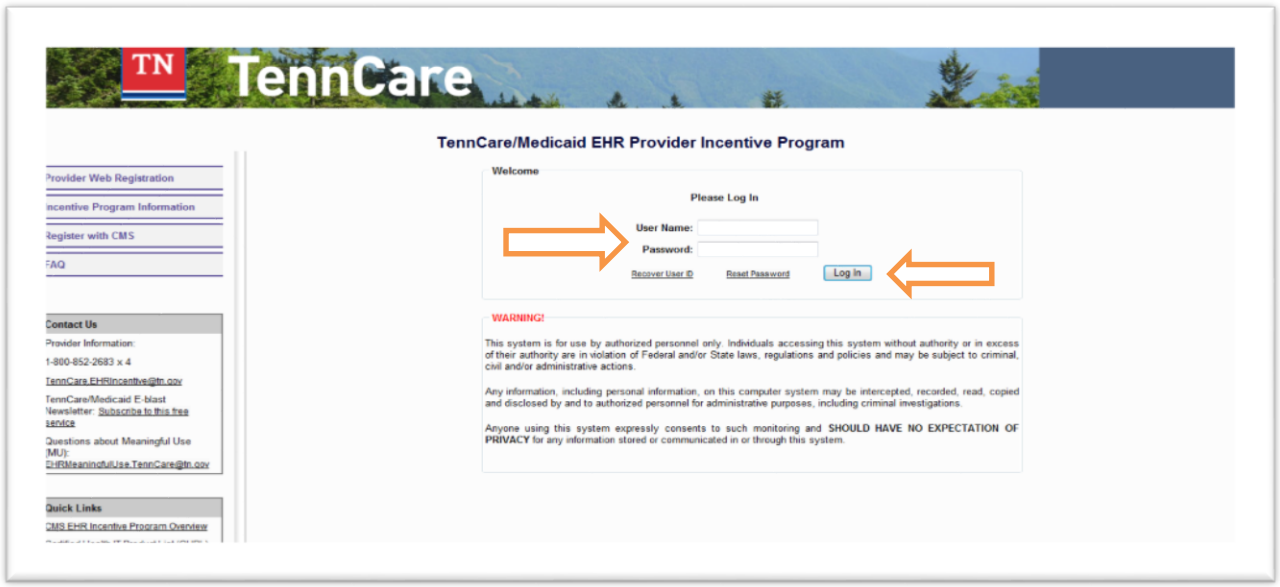
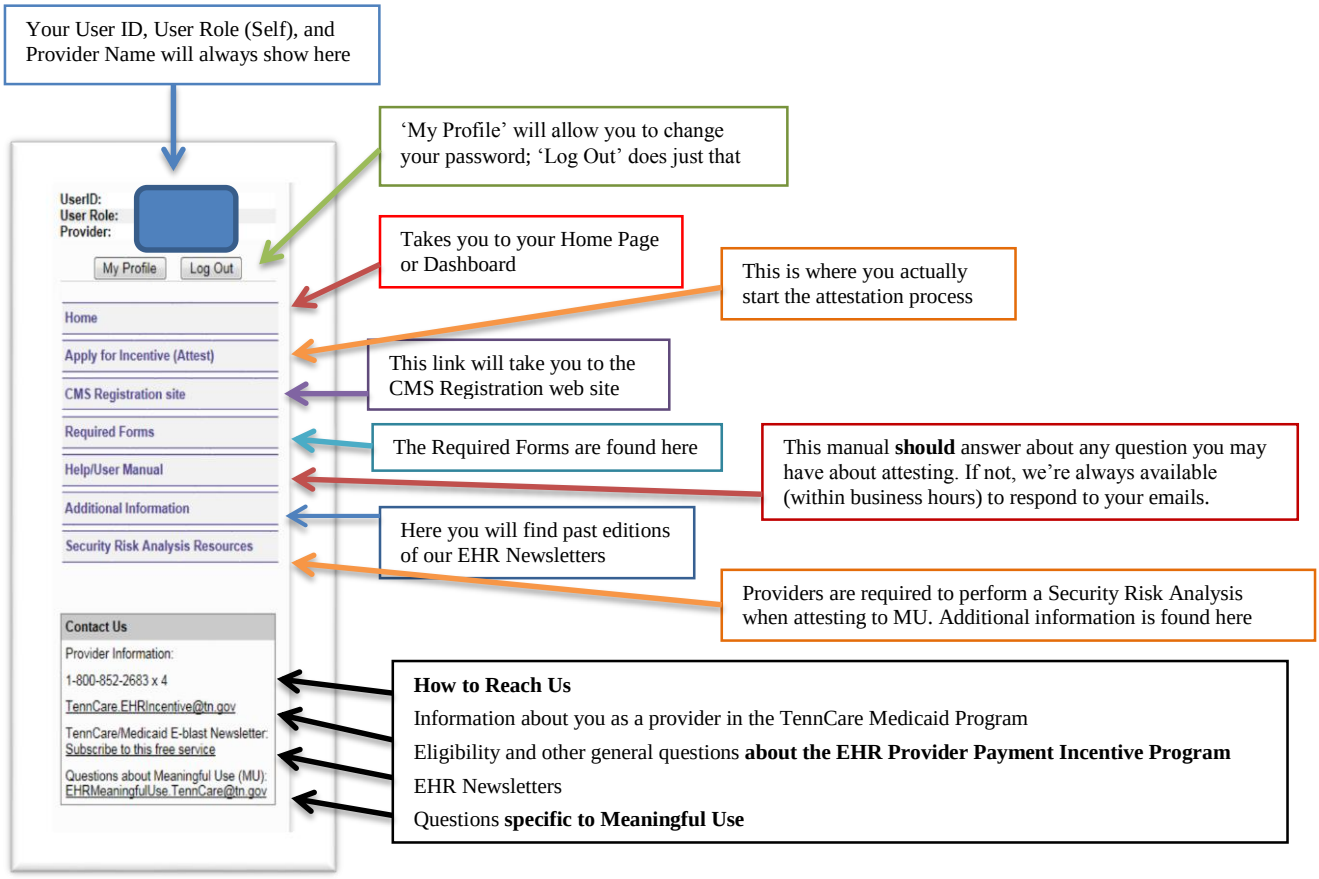


Figure 2 – Established User Log in Screen

The Left Side of the PIPP Portal Page

The left column of portal pages contains several links you will need to use, as well as some that provide additional information or other contacts you may need. This column appears the same on every page of the attestation, except "Apply for Incentive (Attest)." Once you click on that link to start your attestation, it turns gray.



(Lower Part of the same page)

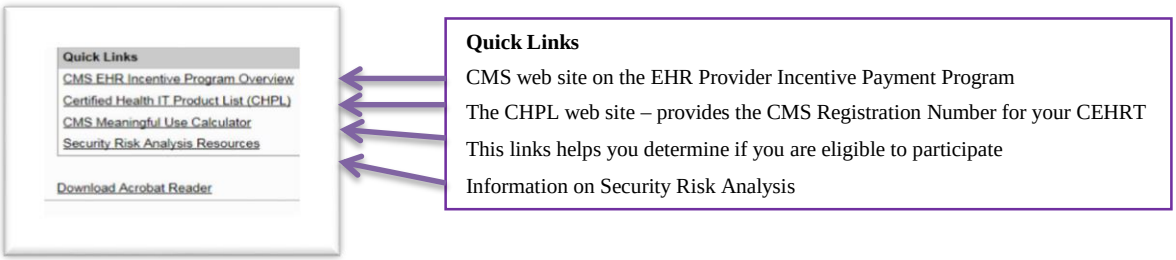


Figure 3 – Left side of Portal Page

2.1.2 Provider Web Registration

Enter the required information to locate your provider profile. This information must match the individual or hospital data used to register with CMS R&A (Figure 4):

- **CMS Registration Number** (This is the number you were given when you enrolled on the CMS R&A web site.)
- **NPI** (Your individual NPI, not that of the group)
- **Tax ID** (**For EPs**, this is your Social Security Number (SSN))

Click 'Find'.

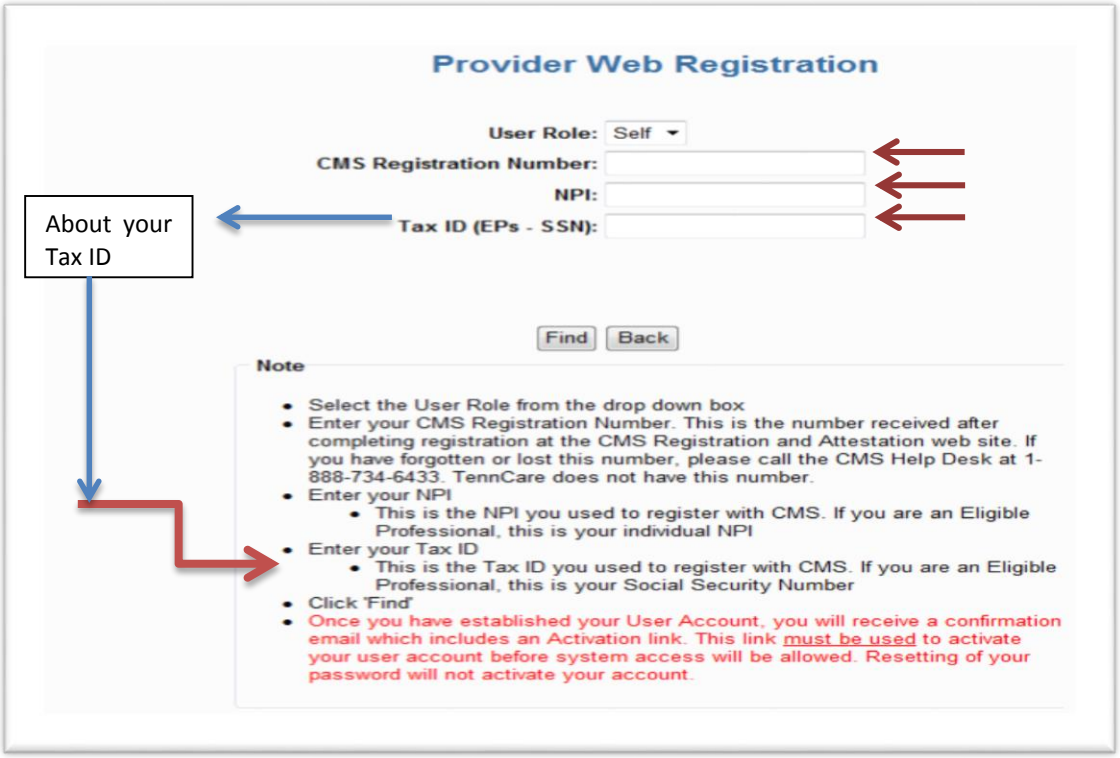


Figure 4 - Provider Web Registration

You will then be taken to the page that requests you establish a User Name, password, and provide answers to three security questions. If you get an error message, first check to see that you entered the requested information correctly. If so, then that means TennCare has not yet received your information from CMS. Please wait 24 hours and try again. If you still have problems after waiting, then contact TennCare.

2.1.2.1 Most Often Seen Problems

As stated previously, unless TennCare instructs you otherwise, providers will only use the link "Provider Web Registration" one time for each provider. If you attempt to use this link a second time without being told to, you will get an error message. In addition, if your User Account is locked, it **cannot** be unlocked by trying to change the User Name and/or password. You must email TennCare for assistance with this problem; **always** include the provider's name and NPI.

For EPs, the most identified problem encountered is where the provider uses his TIN or EIN where the Tax ID number is requested. This field should be completed with the **provider's Social Security Number (SSN)** in order for the search to be successful.

If at any time, you get an error message that the requested provider cannot be found, double check that all requested numbers were entered correctly. It is usually easier to re-key the numbers rather than doing a comparison. CMS Registration Numbers have 10 digits; NPIs also have 10 digits; SSNs are 9 digits; and Hospital TINs have 9 digits.

2.1.3 Create User Name and Password

Once your provider profile is located, the PIPP portal will prompt you to create a User Name and Password. (Figure 5)

Among the information shown, the following fields will be auto-populated with the data received from the CMS R&A. You are responsible for verifying this data is accurate. If any of this data is incorrect, or there is missing information, you must return to the CMS R&A System web site to make corrections. TennCare cannot make the correction for you.

- CMS Registration Number
- NPI
- Tax ID **(EPs – This is your SSN)**
- First Name
- Last Name
- Email Address

NOTE: ***ALL*** *email correspondence will be sent to the address listed on this screen.*

If at **any** time you go back to the CMS R&A System web site, even if you are only looking at the information you previously entered, please refer to Section 2.4. It is important that you follow the instructions found in that section.

2.1.3.1 Create User Name

Please create a User Name using the following properties:

- Must be between 6 and 10 characters long
- May contain a combination of alphanumeric characters
- Must NOT contain non-alphanumeric characters (! @ # % *)
- Must NOT have any spaces
- User Name is not case sensitive

2.1.3.2 Create Password

Please create a Password using the following properties:

- Must be between 7 and 10 characters long
- Must contain at least one non-alphanumeric character (! @ # % *)
- Must contain at least one upper case character
- Must contain at least one lower case character
- Must NOT have any spaces

2.1.3.3 Answer Security Questions

Security questions will be used in the event you need to reset or recover your User Name and/or Password.

Once this page is completed, click 'Save' to create your TennCare PIPP portal user name and password.

The Bureau of TennCare strongly encourages all providers to have more than one person who is able to access your PIPP portal account. In the event an employee leaves, someone else needs to know your User ID, Password, and the answers to the Security Questions. You can change this information in the future if necessary.

Additionally, some providers use consultants to assist them in registering and attempting to qualify for the EHR Provider Incentive Program. This is an acceptable practice and TennCare does not have any objections to providers doing so. However, providers need to be aware that some consultants enter **their** own email address when registering the provider at the CMS R&A web site. As TennCare does all correspondence related to the EHR Incentive Program via email, all email is sent to the address entered when registering at CMS. If you are using a consultant who places their email address in your registration, you need to maintain close contact with the consultant as some attestation problems may require your intervention, as well as to be able to receive other emails we generate, such as the monthly e-newsletter.

2.1.3.3.1 Most Often Seen Problems

Failure to follow the required guidelines when creating User Names and Passwords is our biggest problem here. If you get an error message, double check what you entered.

If your User Account is locked, you **cannot** unlock it by trying to create a new password. If your User Account is inaccessible to you, an email containing the provider's name **and** NPI must be sent to TennCare.EHRIncentive@tn.gov with your request. We will notify you when your account has been unlocked.

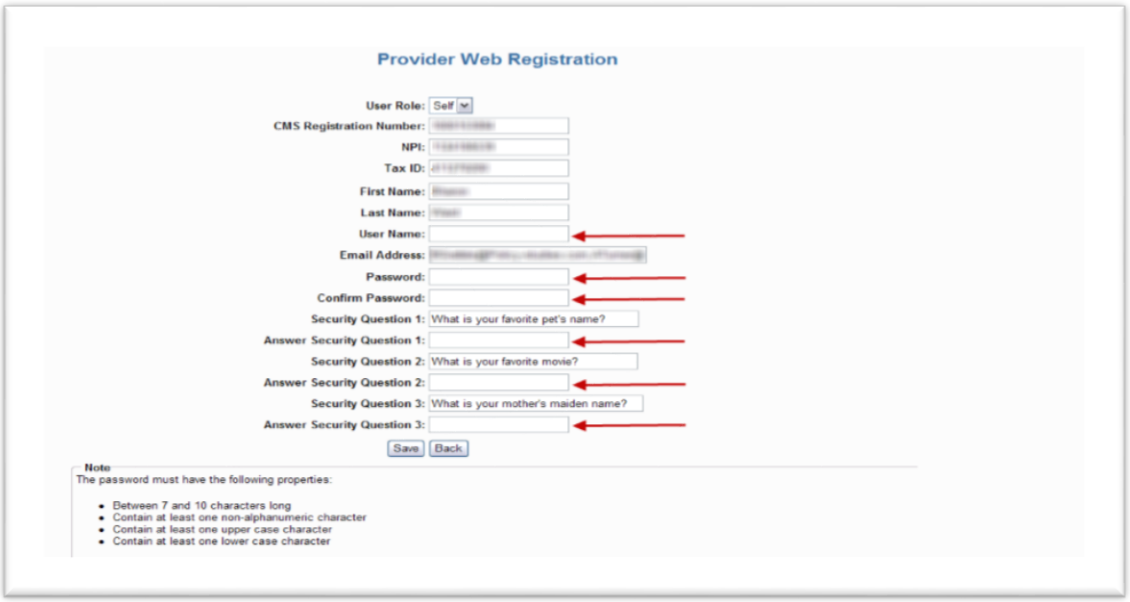


Figure 5 - Create User Name and Password

2.2 Activate & Log In User Account

Once your User Name and Password have been created, an activation email **will be sent to the email address registered** with the CMS R&A system. (Figure 6)

Click on the link provided to activate your account. If the link fails to work, the URL is also listed in the email you received. You can copy and paste the URL to your browser.

Figure 6 – Activation Email

2.2.1 Most Often Seen Problems

Strangely enough, providers will **often** skip this step. You **must** activate your account in order to proceed with attestation. If you do not receive this email shortly after submitting

your user account information, check your Spam box. Sometimes this email is directed there by your email system.

2.3 Recover / Reset Log In Credentials

In the event you need to recover your User Name or reset your Password, please follow these steps:

2.3.1 Recover User ID

Please see Figures 7, 8, and 9.

- Click on 'Recover User ID' link from the Log In page.
- Enter the following information:
  - CMS Registration Number (NLR#)
  - NPI
  - Tax ID (EP – Your SSN)
- An email with your User Name will be sent to the email address on file in the CMS R&A System.

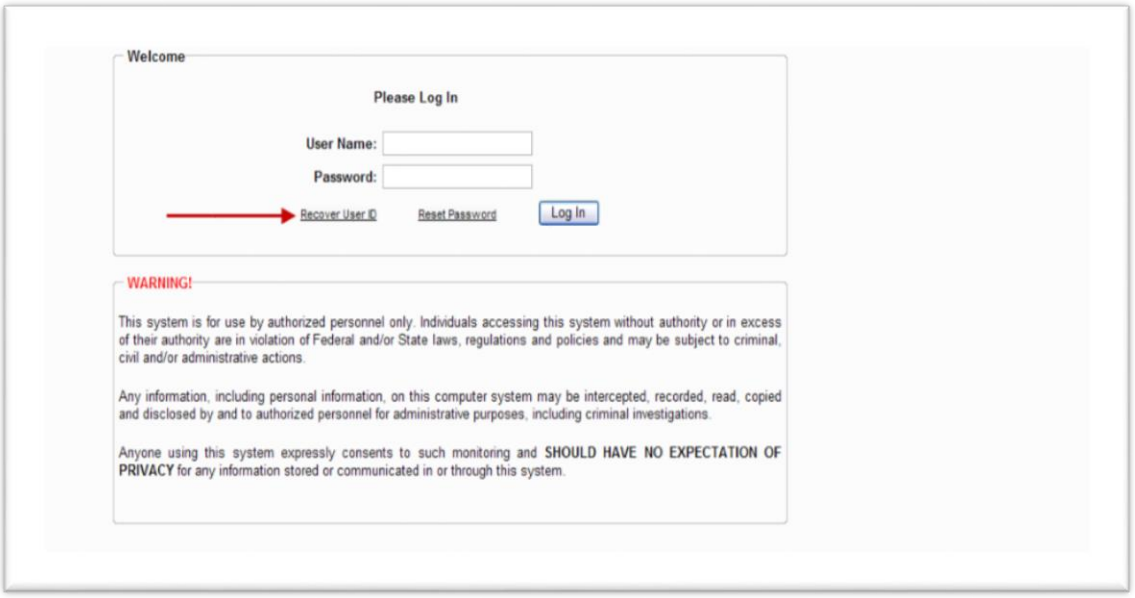


Figure 7 - Recover User ID - 1

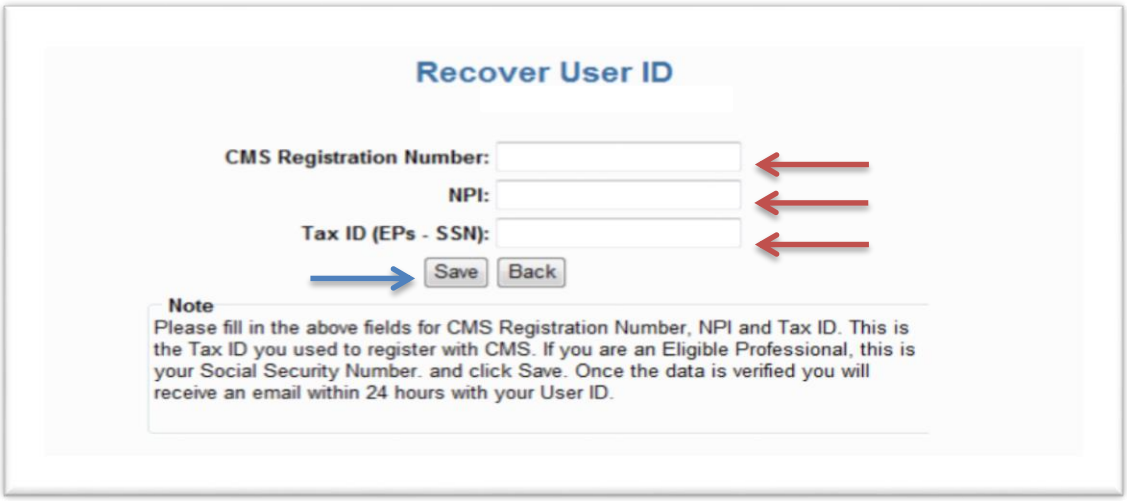


Figure 8 - Recover User ID - 2

Figure 9 - Recover User ID - 3

2.3.2 Reset Password

Please see Figures 10, 11, and 12.

- Click on 'Reset Password' link from the Log In page.
- Enter the following information:
  - User Name
  - Security Question
    - You must provide a correct response to the question on the screen which you provided an answer when creating your User Name
- Click 'Next'
  - You will be taken to a screen to create a new password
- Enter the new password
  - The new password must be different than your previous passwords
  - Also note you will need to use the same guidelines you used when creating your initial password:
    - Between 7 and 10 characters
    - Must contain at least one non-alphanumeric character (! @ # % *)
    - Must contain at least one upper case character

- Must contain at least one lower case character

- Confirm the new password
- Click 'Save'
- You will now be able to log in to the system using your newly created password.

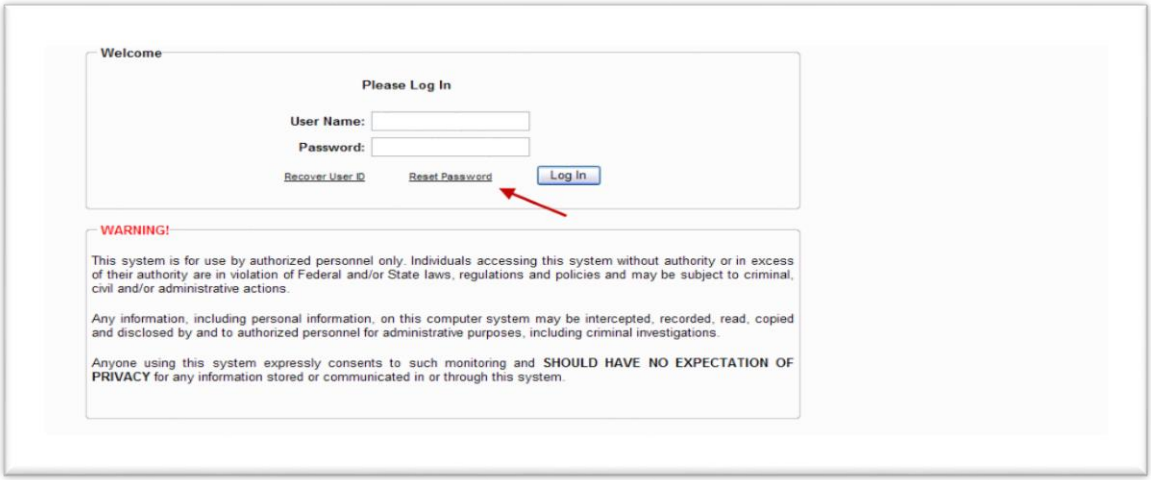


Figure 10 - Reset Password - 1

Figure 11- Reset Password - 2

Figure 12 - Reset Password – 3

2.3.3 Change Password

Please see Figures 13 and 14.

Follow the steps below to change your password.

If you requested a password reset from TennCare, (that is, a new secure password was emailed to you), you will be required to change that password the first time you log in. Log in as you normally would, use the temporary password sent you by TennCare, if appropriate. To make this change, please enter the temporary password from the email in the 'old password' field.

If you would like to change your password at any other time, you will need to enter your password you are currently using in the 'old password' field.

- Log in
- Click on 'My Profile' on the left of the Dashboard
- Enter your old password
- Enter and Confirm your new password
- Answer security question
- Click 'Save'

If you are locked out by the system, send an email to TennCare.EHRIncentive@tn.gov and explain what happened. Changing the password will not "unlock" the account. Always include the provider's name and NPI.

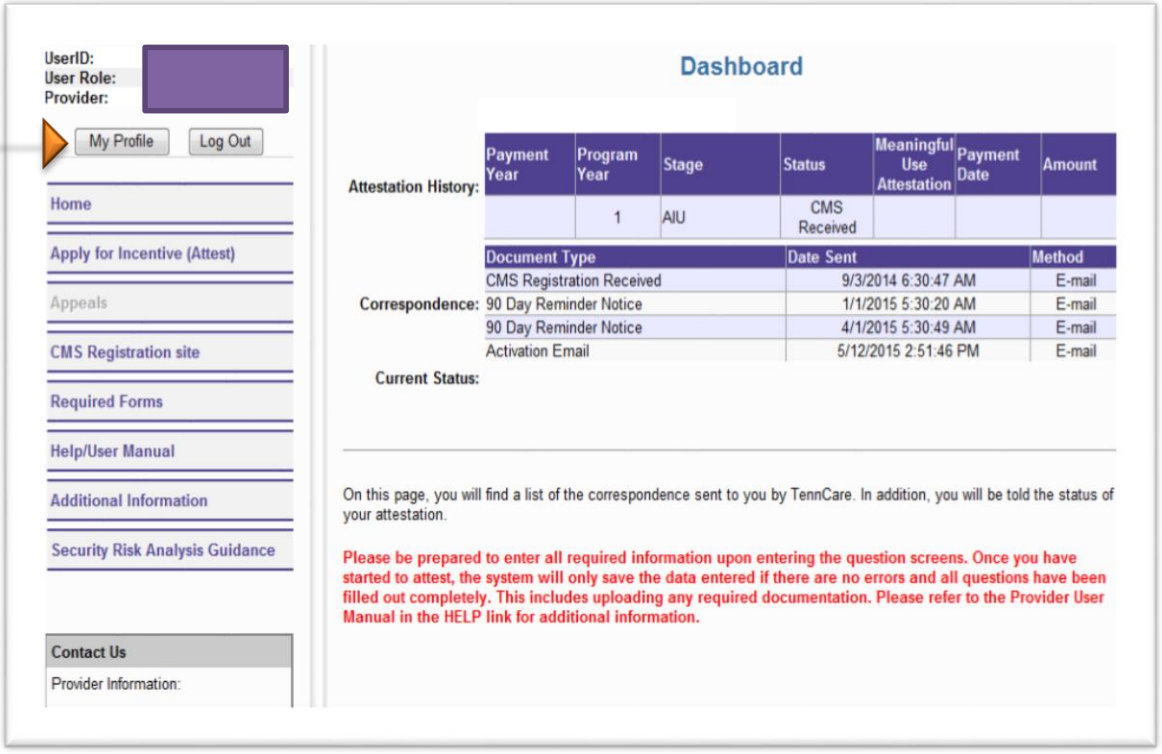


Figure 13 - My Profile - Change Password – 1

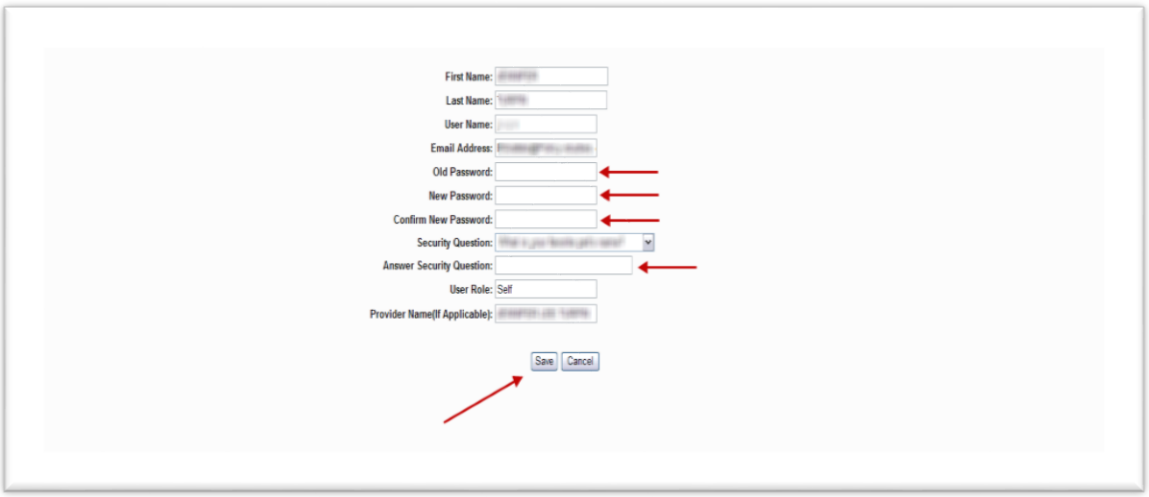


Figure 14 - My Profile - Change Password – 2

2.4 Updating the CMS Registration & Attestation System (R&A)

There are several reasons why providers may go back to the CMS R&A web site. Among these reasons are:

- To make a change to the Payee NPI of the EHR Incentive Payment
- Failure to enter the CMS Certification Number of your certified EHR System or module(s)
- Change the Email address on record
- Just to check to see what information was previously submitted

Regardless of the reason why you return to the CMS R&A web site, you **must** follow these steps:

- Go to the CMS Registration & Attestation System web site
- Enter the CMS Registration Number you were originally given when registering
- Click on "Modify"
- On **EACH** page, click "Save & Continue"
- On the appropriate page(s), make the needed change(s), click "Save & Continue"
- On the last page, click "Submit"

When you re-open your CMS Registration, CMS automatically puts your account in a "hold" status. This status prevents TennCare from any further processing of your registration or attestation.

Failure to follow these steps as listed will result in your changes not being saved or being forwarded to TennCare. **Even if** all you are doing is checking what you previously entered, you **must complete** each step, other than making a change if one is not needed.

Should you appear on a daily list we receive from CMS of providers who failed to complete each step, we will send you up to five email reminders. CMS does not tell us

why you appear on the daily list. The CMS Help Desk may be able to assist you by calling 1-888-734-6433. It is **your** responsibility to identify and correct the problem.

3. Navigating the TennCare PIPP Portal

3.1 Log in to TennCare PIPP Portal

When you click on the link provided in the activation email, or copy and paste the URL into your browser, you will be directed to the TennCare PIPP Portal Log In screen - https://pipp.tenncare.tn.gov/Login.aspx?TimeOut=False (Figure 15).

Enter your User Name and Password to begin Attestation.

Note: It is on this page that you can recover your User ID and/or reset your password. You must know the answers to your security questions to accomplish either of these tasks. This is why we recommend more than one person have or have access to this information, in case someone leaves, another individual will be able to access the portal.

Figure 15 – Established User Log in Screen

3.2 Review Communications Log & Attestation Status/History

After logging in, the Dashboard will display your attestation history (first arrow), and any communications (second arrow) that have been sent to the email address registered with the CMS R&A system. It will also show the status (third arrow) of your attestation (first arrow). (Figure 16)

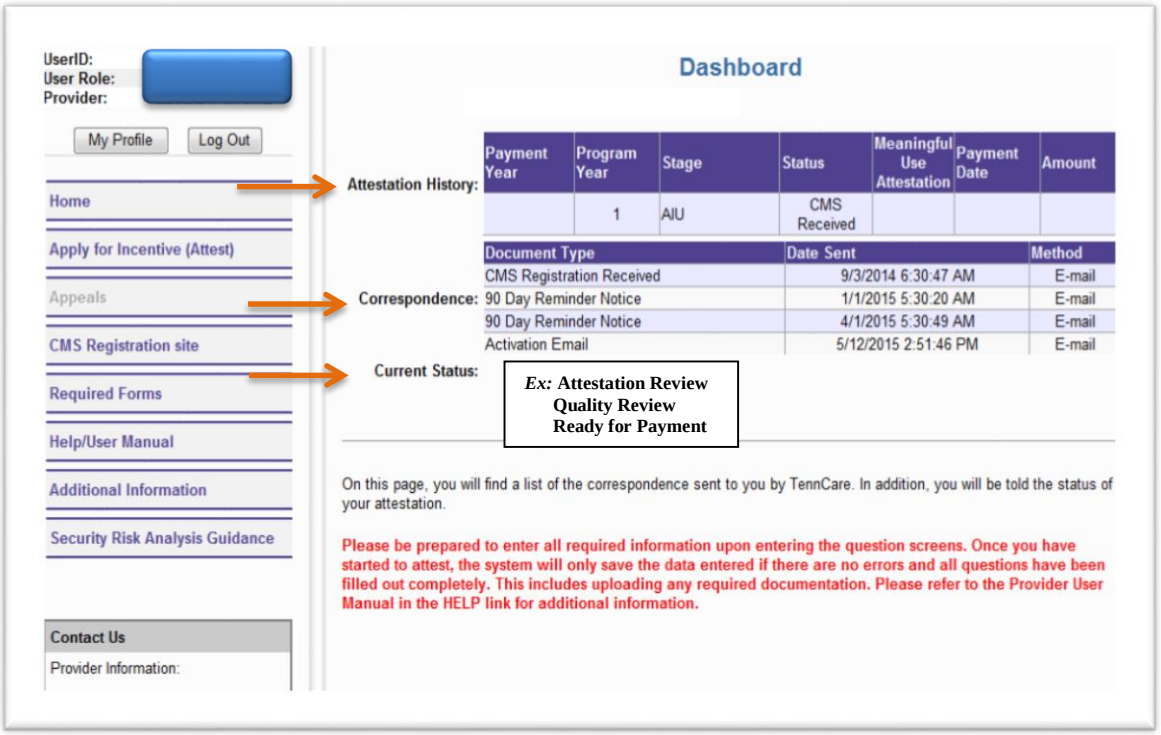


Figure 16 - Dashboard

This Status Table lists the status headings you will see and their meaning.

Status	Meaning
CMS Received	The notification of EHR registration has been received from CMS. An e-mail has been sent to the Email address registered with CMS to invite you to create a User Account.
Attestation Pending	You have begun the attestation process, but have not yet submitted your attestation. You can modify your attestation at any time before submitting it for review.
Eligibility Attestation Returned	If your attestation is returned to you for reasons regarding the information you have submitted, the status will be reset to Attestation Pending so that you can once again access your attestation in a modifiable form. You can modify your attestation before resubmitting.
Attestation Review	You have completed your attestation and submitted it for review.
Audit Review	Your attestation is being processed by TennCare.
Audit Review Complete	Your attestation is being processed by TennCare, and a problem has been identified. TennCare will contact you via e-mail if necessary.
Quality Review	Your attestation is being processed by TennCare. This status only applies to providers attesting to meaningful use.
Quality Pending	Your attestation has been returned to you for reasons regarding your meaningful use (MU) attestation. The status has been reset so that you can once again access your MU

Status	Meaning
	attestation in a modifiable form. You can modify any aspect of your MU attestation before resubmitting.
Pending CMS Payment Review	Your attestation review has been completed by TennCare and your information submitted to CMS to receive clearance for payment.
Ready for Payment	CMS has notified TennCare that you have been cleared for payment, and your payment may take up to 30 days to be issued after your attestation reaches this status.
Payment Rejected by CMS	CMS has notified TennCare that you are not cleared for payment; you will receive an e-mail from CMS with the reason. CMS does not inform TennCare why payment has been rejected.
Payment Pending	Your payment is being processed by TennCare, and your payment may take up to three weeks to be issued after your attestation reaches this status.
Payment Complete	Your payment has been issued by TennCare. Payments usually appear on the Friday Remittance Advice (RA).
Attestation Denied	Your attestation has been denied. A letter of explanation will/has been sent to you.
Meaningful Use Attestation Returned	
Cancelled by CMS	CMS will cancel attestations at your request, when you change from Medicaid to Medicare for attestation purposes, or if you change the state program in which you are attesting (ex: from Tennessee to Oklahoma).
Appeal Pending	Your appeal has been received by TennCare.
Appeal Denied	Your appeal has been processed and denied by TennCare
Sent to OGC*	You have requested a contested hearing.

Table 1 - Status Descriptions ***TennCare's Office of General Counsel**

3.3 How to Initiate Attestation

On the left side of the Provider Dashboard screen, click on the 'Apply for Incentive (Attest)' link. (Figure 17)

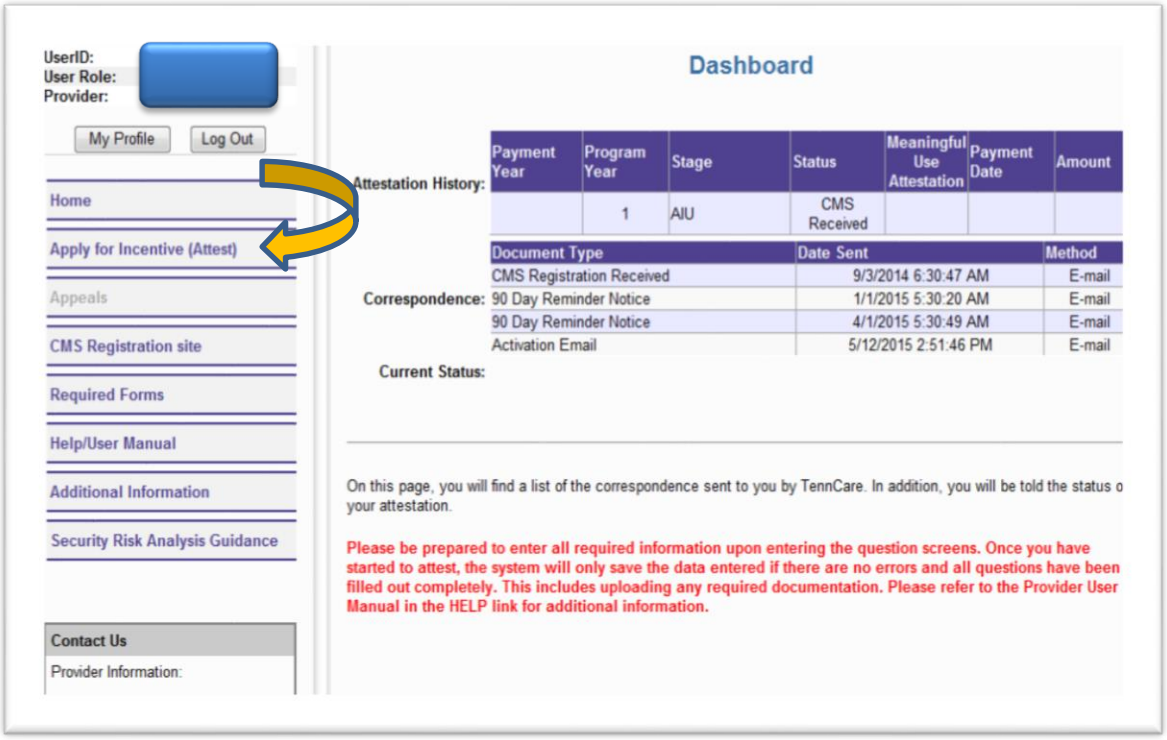


Figure 17 - Apply for Incentive (Attest)

3.4 *Uploading Supporting / Required Documentation (Add Document)*

All Attestation screens in the TennCare PIPP portal allow for the upload of supporting documentation, while some screens require supporting documentation be uploaded. This is done by utilizing the "Add Document" button on the bottom left of each page. Please follow the steps below to upload your documentation wherever applicable.

Do NOT include patient medical records (PHI) as documentation. For proof of EHR documentation, do NOT send a copy of the entire contract or lease. See the FAQs or the EHR Questions screen for more information.

NOTE: For security purposes, the documents that can be uploaded are limited to the following file types:

- Excel - .xls, .xlsx
- Word - .doc, .docx, .rft
- Power Point - .ppt
- Text - .txt
- PDF - .pdf
- Images - .jpg, .jpeg, .gif, .png, .bmp, .tiff

3.4.1 Add Document

- Click 'Add Document' button (Figure 18)
- Click on 'Document Name' drop down box to select your document type (Figure 19)
  - This drop down box will vary depending on the Attestation screen to which you are uploading.
  - There is also the option for "Other." Give a short descriptive name of what you are attaching and then upload.
- Click 'Upload Document'. (Figure 20)
  - Select file to be uploaded
- Once file is done uploading and the selected file name appears in the 'Document File Name' field – Click 'OK'. (Figure 21)
- You will be returned to the main screen of the selected Attestation. To upload another document, please repeat the first four steps above.

NOTE: *The current file size limit is 5MB.*

Do NOT include patient medical records (PHI) as documentation. For proof of EHR documentation, do NOT send a copy of the entire contract or lease. See the FAQs or the EHR Questions screen for more information.

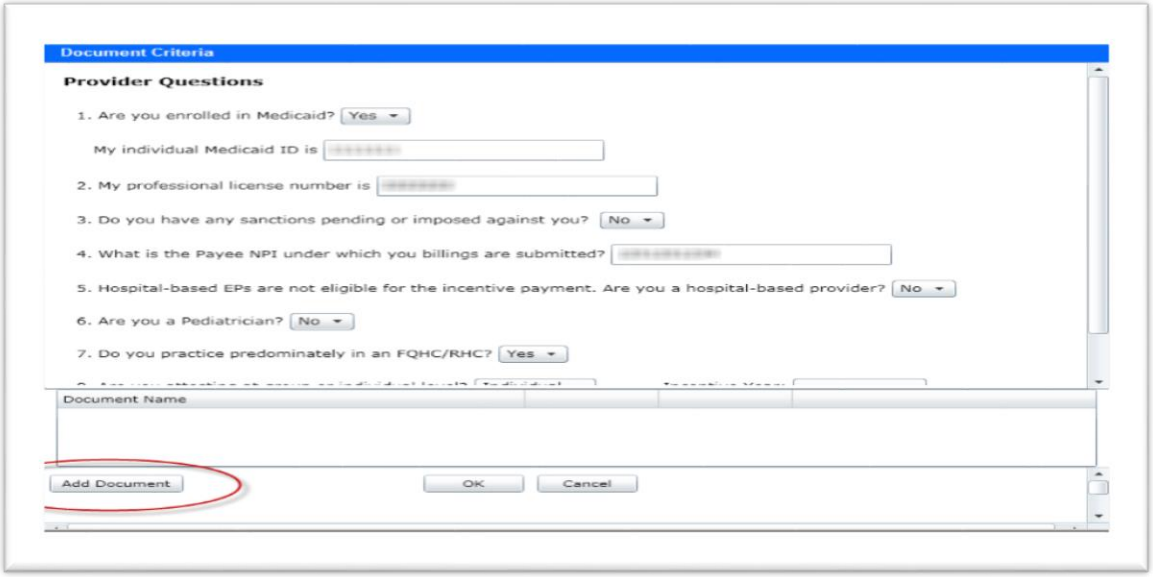


Figure 18 - Add Document - Step 1

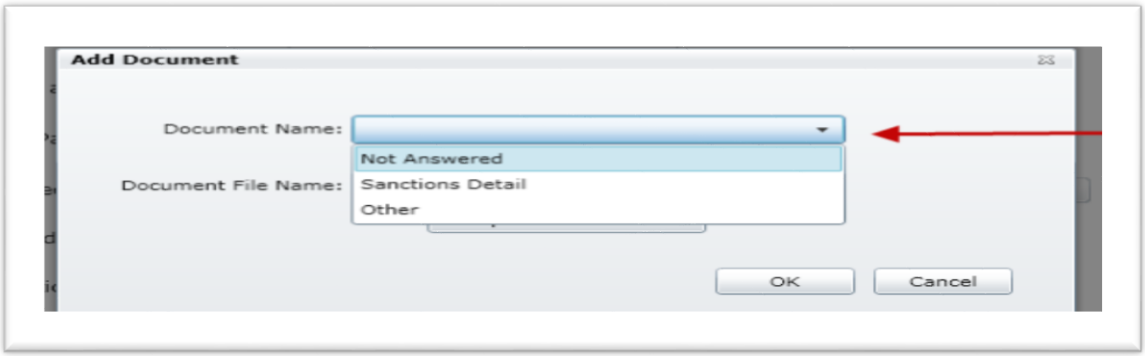


Figure 19 - Add Document - Step 2

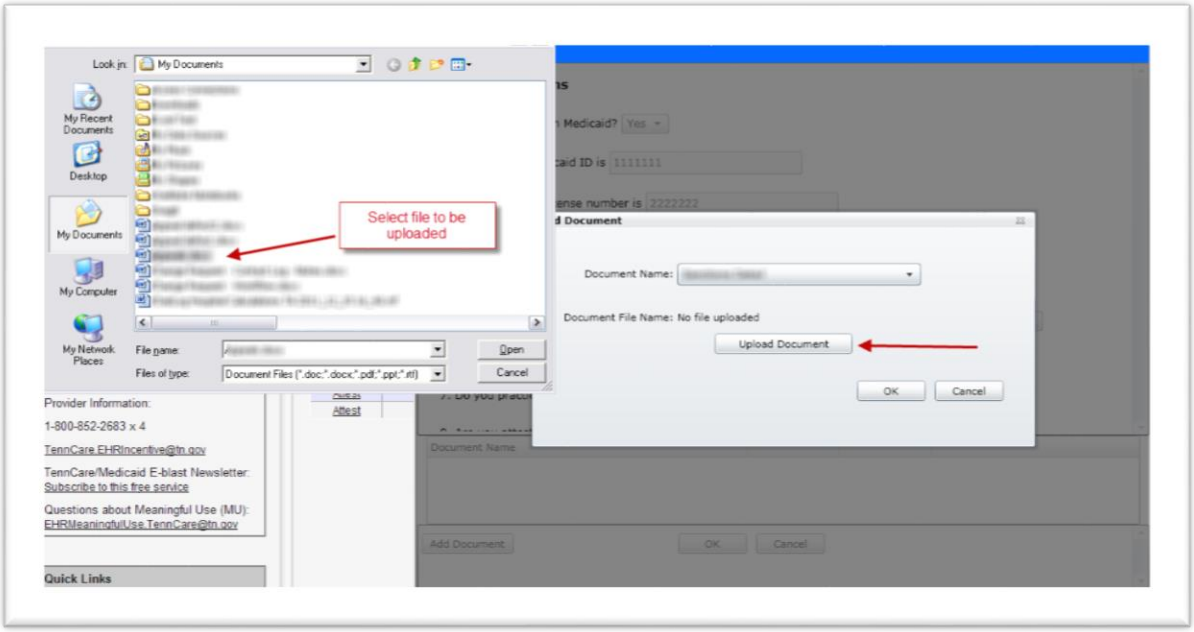


Figure 20 - Add Document - Step 3

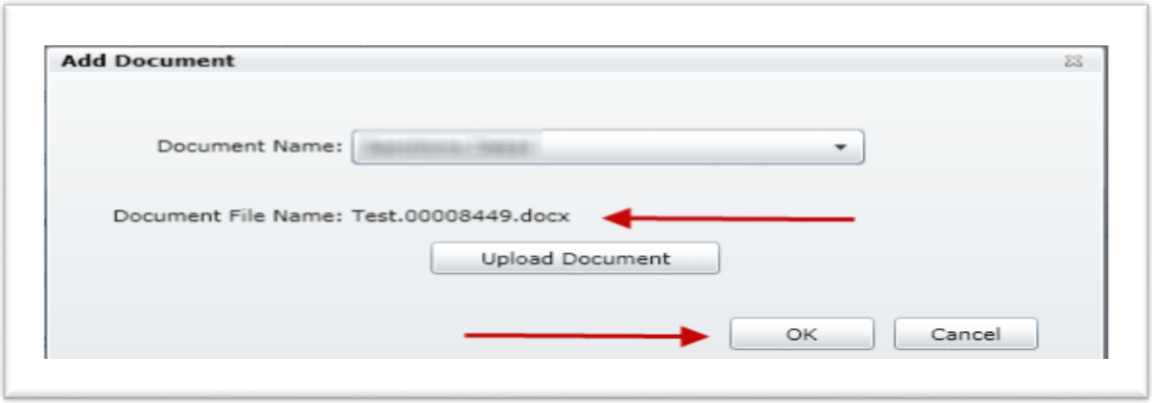


Figure 21 - Add Document - Step 4

4. Eligible Professional (EP) Provider Attestation Instructions

Note: You are required to complete the appropriate pages for each year of attestation.

Note 2: If you have questions or comments about this section, send an email to TennCare.EHRIncentive@tn.gov.

This section provides instructions for EPs attesting, whether they are attesting for the first time (Program Year 1), or for subsequent years. The first four screens must be complete for **each** year in which you apply for an EHR Incentive Payment, including **all** documentation. The screens must be completed in order to avoid a problem. These four screens are:

- Provider Questions
- EHR Questions
- Required Forms
- Patient Volume Questions

Section 4.3 covers the process for attesting to Meaningful Use in Years 2 through 6.

Clicking on 'Apply for Incentive (Attest)' link (See Section 3.3 above) will display the Provider Attestation screen. Under the Provider EHR Criteria heading, attestation categories will be displayed. Begin attestation by selecting one of the 'Attest' links. (Figure 22)

Note:

Please be prepared to enter all required information upon entering the question screens. Once you have started to attest, the system will only save the data entered if there are no errors and all questions have been filled out completely. This includes uploading any required documentation. ***While you can stop and save information in the Meaningful Use Section without losing your information, information about CQMs cannot be saved.***

4.1 The Provider Attestation Home Page

Figure 22 shows an example of the Provider Attestation Home Page. After you complete the answers on each page, you will return to this page. The box provides some identifying information about you. The status of your attestation as well as the date of the status reported is given.

The **'Provider Eligibility Criteria'** section shows that you have registered with CMS and the date the information was received by TennCare.

The **'Provider EHR Criteria'** section shows the Attestation questions that must be completed **each year**. You must respond to all of the questions on each page (click "Attest" in the first column). Once you have answered the questions on a page, click "OK" and you will return to this page. "Pend" will then appear in the first column. Up until you submit your information for review, you may go back and change your responses. Once you submit your attestation, you will not be able to change any information unless we return the attestation to you. The headings under this section are described below.

Criteria: Each page must be answered to apply for an incentive payment. Some if the information will be pre-printed.

- Provider Questions – Information about you
- EHR Questions – Information about your certified EHR system/module(s); you will be asked to upload documentation that proves you have or have access to a certified EHR system/module. This must be done for **each** year of the EHR Provider Incentive Program. If you change certified EHR systems, the box where you enter your CMS Certification Number is an editable field. This means you can enter your new certification number here.
- Required Forms – You are required to upload a new signed & dated Signature Page for each year of attesting.
    - TennCare has two additional required forms that affect only Nurse Practitioners (NPs) and Physician's Assistants (PAs) practicing in an FQHC or RHC.
        - For NPs, we are asking for information about the doctor or other proctor, including the Group NPI, under which the NP is submitting claims. While TennCare allows this procedure, not knowing this information makes it difficult to us to verify patient encounter volume.
        - PAs are eligible to participate in the EHR incentive program if they work in a PA-led FQHC or an RHC so led by a PA. TennCare requires information about the FQHC/RHC (name. address, and a copy of the letter indicating the status of the facility as that of an FQHC or RHC) and the name and NPI of the lead PA. **All** PAs in an FQHC or RHC are eligible to participate if their facility is led by a PA.

          See Section 3.4 on how to add a document.

- Patient Volume – Submit information about your total patient encounters and total Medicaid encounters (non-FQHC/RHC providers). If you practice predominately in an FQHC or RHC, use total Needy Individuals encounters, which include Medicaid encounters. Definitions of both are found using the "hovers" on this page.
  Note: when talking about Medicaid and/or TennCare enrollees, providers should understand that this also applies to individuals enrolled in the Medicaid program of another state.

🕮 How is a Medicaid encounter defined?

A Medicaid encounter is defined as services rendered to an individual on any one day where

➲ For EPs
- TennCare paid for all or part of the service
- TennCare paid for all or part of the individual's cost sharing
- The individual was enrolled in TennCare (or another state's Medicaid program) at the time the billable service was provided.

➲For EPs practicing in an FQHC or RHC (Needy Individual)
- TennCare paid for all or part of the service
- TennCare paid for all or part of the individual's cost sharing
- The individual was enrolled in TennCare (or another state's Medicaid program) at the time the billable service was provided.
- The service was furnished at no cost
- The service was paid at a reduced cost on a sliding scale based on the individual's ability to pay

So, what does "The individual was enrolled in TennCare at the time the billable service was provided" mean? Providers may now count claims denied under certain circumstances when counting patient encounters.

For example, if a claim was denied because it was filed late, or the service exceeded service limits, or it is a service not covered by TennCare, a provider may count that encounter when calculating patient volume. However, if the claim was denied because the individual was not enrolled in TennCare (or the Medicaid program of another state) on the date of service, that claim cannot be included as a patient encounter. Or if the provider was not enrolled as a Medicaid provider and contracted with at least one of TennCare's Managed Care Contractors (MCCs), then that claim could not be counted.

- **Status** – "Pending" will appear in this column until you complete each page. "Attested" will appear once each page is completed.

- **Received Date –** This is the date that you completed a particular page.

- **Action –** If the attestation is returned to the provider to correct information or the attestation is denied, the reason will be shown here.

- **Attested –** "No" will change to "Yes" as you complete each page.
- (See 4.2 on how to submit the attestation for review once every section is complete.)

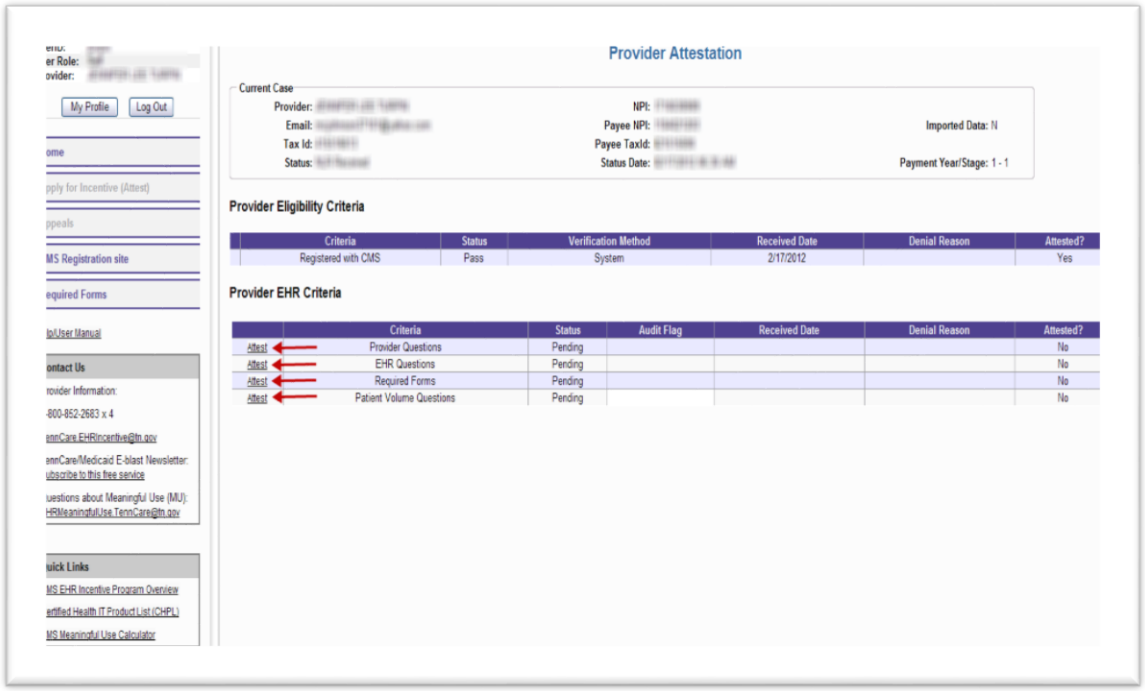


Figure 22 - EP Provider Attestation

4.1.1 Provider Questions

Please see Figures 23 and 24.

1. Are you enrolled in Medicaid?
   - Yes – Enter your **Individual** Medicaid ID number (MID); **not** your group MID
   - No – Please contact TennCare Provider Services to enroll (Provider.Registration@tn.gov)

2. My professional license number is:
   - Enter your Tennessee-issued license number (NPs/APNs – this is **not** your RN license number)

3. Do you have any sanctions pending or imposed against you?
   - Yes – A text box will be displayed for a brief description of the sanction(s). The description is limited to 100 characters. Please upload any necessary supporting documentation or comments.
   - No

4. What is the Payee NPI under which your billings are submitted?
   - Please enter your Billing/Payee NPI

5. Hospital-based EPs are not eligible for the incentive payment. Are you a hospital-based provider?
   - Yes – You cannot be hospital-based and complete Attestation. An EP is defined as being hospital-based, and therefore ineligible to receive EHR incentive payments under either Medicare or Medicaid, regardless of the type of service provided, if 90 percent or more of their professional services are identified as

being provided under place of service codes 21 (Inpatient Hospital) or 23 (Emergency Room, Hospital).

IMPORTANT: The Stage 2 Final Rule (79 FR 52910) made a change whereby certain EPs who do provide a majority of their professional services in a hospital, **may** qualify for an EHR incentive payment if such provider has his own EHR system and files an application with CMS. CMS will use this application to determine if the EP is eligible to apply for an incentive payment. Contact CMS for more information. *TennCare does not have any involvement in whether this option is granted; it is solely under CMS authority.*

- No

NOTE – *The only exception to this rule are Medicaid EPs practicing predominately in an FQHC or RHC; in this situation, you should click "No."*

6. Are you a Pediatrician? – This question is **asked only** of physicians as Tennessee only recognizes physicians as pediatricians. When doing Meaningful Use attestation, providers will be able to inform us of their specialty.
   - Yes – The Patient Volume threshold for Pediatricians is 20%. Pediatricians that have at least a 20% Medicaid patient volume but less than 30% will receive a reduced incentive payment. (See FAQs for information about reduced payment for pediatricians.) **IF** your patient encounter volume is 30% or more, you will be eligible for the full EHR Incentive Payment. *However, we verify what you tell us. Don't just stop counting and assume we will find the rest.* ***Our decision is based on what you submit.***
   - No

The numbering of the remaining items will depend whether the "pediatrician" question is asked.

7. Do you practice predominately in an FQHC/RHC?
   - Yes – EPs that practice predominately in an FQHC or RHC are not subject to being excluded as Hospital-Based EPs and are to use the Needy Individual population to meet their Patient Volume threshold of 30%. "Practicing predominately" definition: over 50% of a provider's total patient encounters over a 6-month period in the most recent 12 months prior to attestation occurred at an FQHC or RHC. This requirement will be validated during the post-payment audit if the provider is selected for audit.
   - No

8. Are you attesting at group or individual level (for patient volume)?
   - Group
   - Individual

Provider groups must agree to attest to encounter data either individually or as a group. If attesting as a group, the group encounter data will be used for calculating Patient Volume; however, each individual provider within that group is still responsible for submitting their individual attestation in order to qualify. That is, the patient volume data for all providers in a group or clinic who are using the group encounter data as a proxy for their individual data, will be the same. **All** other

information requested is about the individual provider who is attesting. When calculating patient volume:

(1) Add together the encounters of each individual provider, including those of other healthcare professionals who are in the group (example: RNs and pharmacy encounters where the group/clinic includes a pharmacy),
(2) Plus those submitted under the group NPI,
(3) Plus encounters provided in a hospital setting: POS 21 (inpatient) and POS 23 (emergency department).
[5]
This calculation gives both your Total Medicaid encounters and Total encounters.

Meaningful Use Attestation is on an individual provider basis. See Section 4.3 for more information.

Incentive Year – tell us for which Program Year you are attesting. This is especially important when you are attesting for the previous Program Year during the 90-day grace period (January 1 – March 31). After the grace period has ended, this field is automatically set for the current calendar year.

9. Do you practice in multiple locations?
   - Yes – Click on 'Add Address' to enter the addresses of all locations where you provide services.
   - No

10. EPs can choose to attest to AIU or MU in their first year of program participation without reducing their payments or years of eligibility. To what are you attesting?
    - Select AIU or MU from the drop down box. This question will only appear when the attesting provider is attesting for the first time. Such a provider can choose to attest for AIU or for MU (which could impact Medicare payment adjustments for dual Medicare-Medicaid providers) for the first year's attestation. This does **not** include providers who have previously attested in the Medicare EHR Incentive Program or the incentive program of another state.

IMPORTANT: 2016 is the **last year** providers who have not previously attested in the Medicaid program of another state, can enroll and begin attesting in the EHR Incentive Program.

Upload supporting documentation.
- Sanctions Detail
- Other

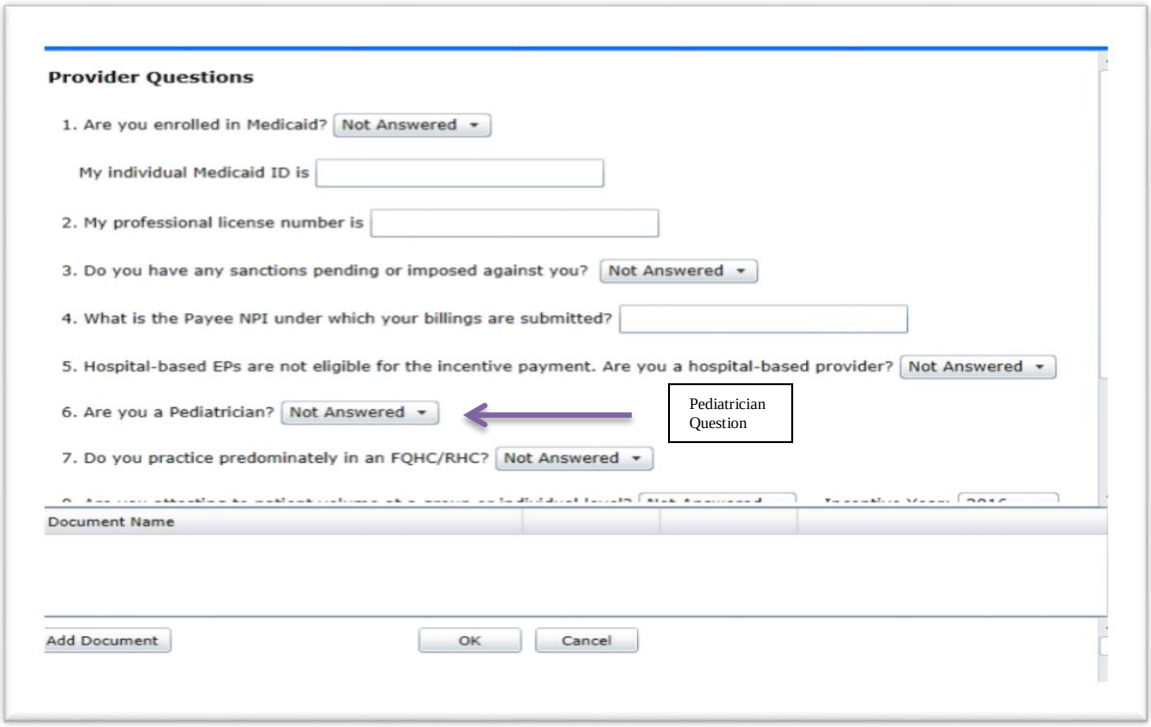


Figure 23 - EP Provider Questions - 1

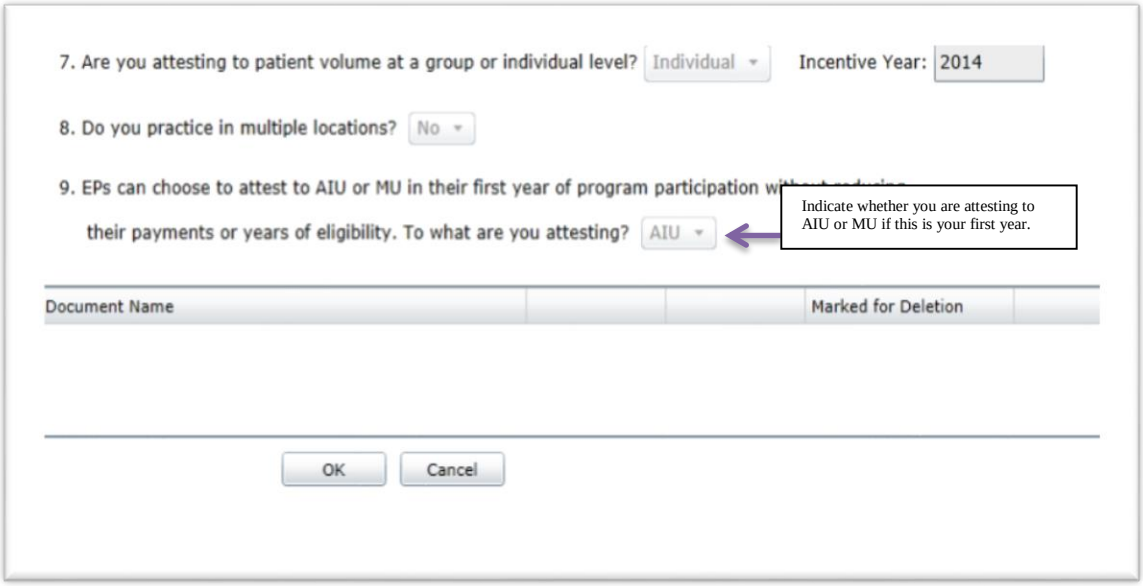


Figure 24 - EP Provider Questions – 2

4.1.2 EHR Questions

Please see Figures 25 and 26.

1. Have you adopted, implemented or upgraded to certified electronic health record (EHR) technology? This information must be provided each year of attestation.

- Yes
- No – In order to attest, you must have adopted, implemented or upgraded to certified electronic health record technology. Please see FAQs for more information.

2. This is your CMS EHR Certification number:
   - Please verify this number is correct. If this number does not match your records please correct at the CMS R&A web site – a link to CMS is available on the left side of the Attestation screen.
   - For years 2 – 6 of the EHR Incentive Program, the EHR Certification Number will not be pre-populated. You must enter the EHR Certification Number. It must match exactly to the CHPL web site.
   - If you have the same system as the previous year, you must still upload documentation as you did the previous year.
   - If you have changed systems or added modules that change your CMS certification number, you must provide the name of your system and/or module(s), version number (if appropriate), and the ONC certification number (in the description box) if you have it.

3. Name, version, and description of Certified EHR System:
   - Enter the exact name, version (if appropriate) and a brief description of your Certified EHR System in the text box provided. The text box is limited to 100 characters. Should the text box not provide enough space, please attach a separate document (Using 'Add Document' at the bottom of the page) listing each system and/or module(s) by name, version number (if appropriate), and ONC certification number, if you have it.

Upload supporting documentation

Providers are required to submit proof of a legal and/or financial obligation showing that they have adopted, implemented, or upgraded to certified EHR technology (CEHRT). Documentation must be submitted **EACH** year in which you attest for an incentive payment. The following list is acceptable documentation of a legal and/or financial obligation.

- The page of an executed contract or lease agreement clearly showing the CEHRT, vendor, and provider, **AND** the executed dated signature page showing both the provider's and vendor's names and signatures.
- If your current contract/lease requires the vendor to provide you with appropriate updates/upgrades to your system to qualify it as CEHRT, executed upgrade agreements for which a cost and timeframe are stated, **AND** identifies your CEHRT.
- A copy of the vendor's invoice clearly identifying your CEHRT, **AND** proof of payment.
- A copy of your purchase order identifying the vendor and the CEHRT being acquired, **AND** proof of payment.
- If using one of the free CEHRT, documentation requirements are a signed letter on the vendor's letterhead identifying the provider and CEHRT, **AND** a copy of the User Agreement.

NOT acceptable as documentation:

- A screenshot of CHPL showing the CMS certification number of your CEHRT
- A screenshot of your computer showing your CEHRT
- Requests for Proposals (RFPs) or vendor bids

- For your documentation to be **valid, it must identify** the CEHRT system that you are using. For example, if you are using item 1 above – the executed contract or lease and signature page – if the first page does not identify your CEHRT, then you must include the page(s) which do.
- Other than when a provider is using a free online CEHRT where a vendor's letter is required, we **DO NOT** accept vendor's letters or other statements as proof of a legal and/or financial obligation for access to a CEHRT system.
- When you are upgrading from one edition of CEHRT, such as from the 2011 Edition to the 2014 Edition, your documentation must clearly show this upgrade occurred.

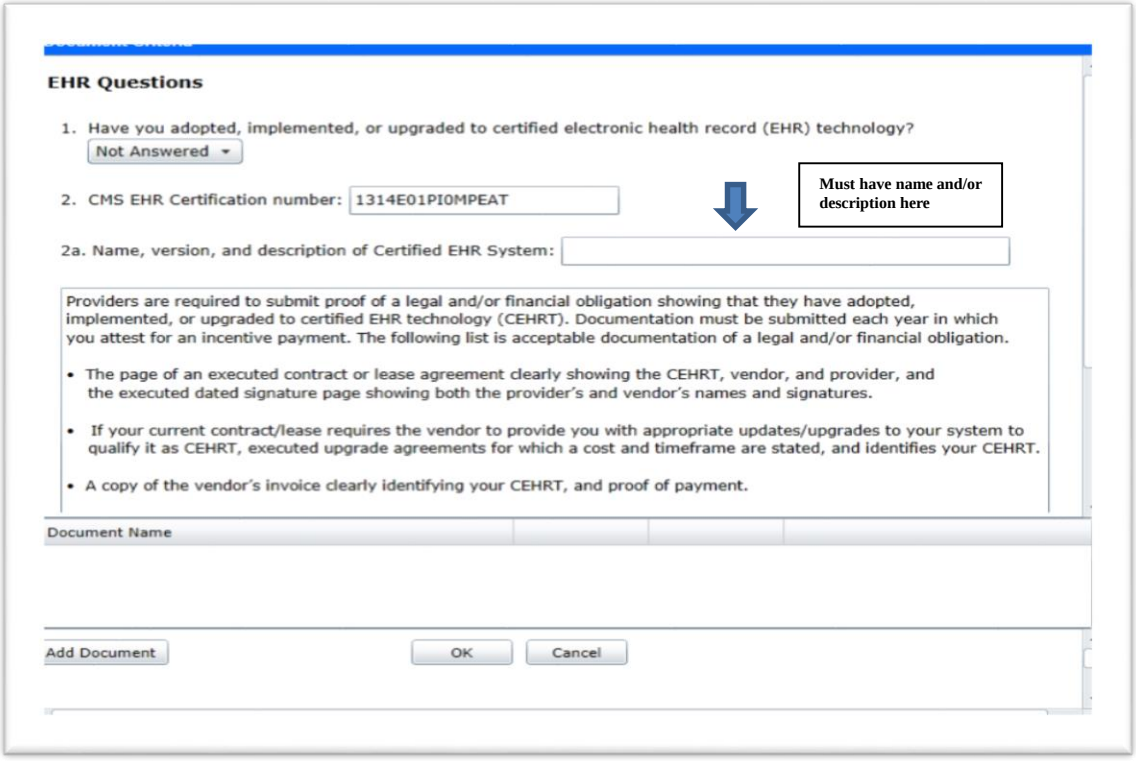


Figure 25 - EP EHR Questions - 1

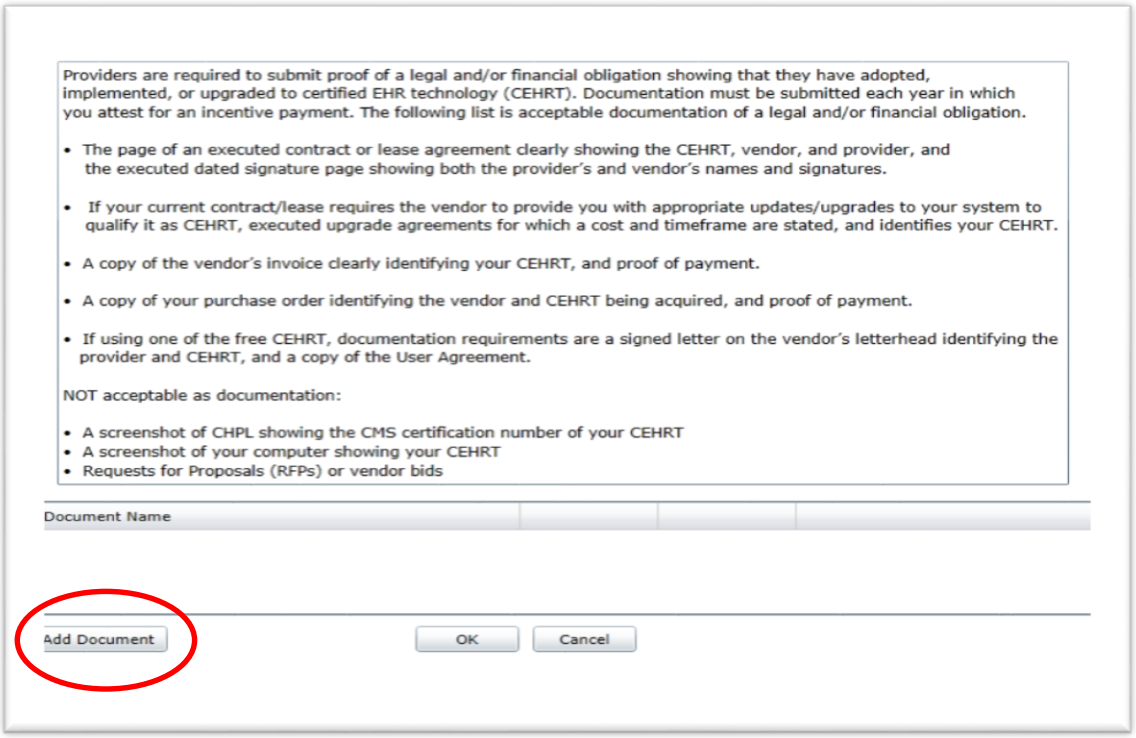


Figure 26 - EP EHR Questions - 2

4.1.3 Required Forms

Please see Figure 27.

All forms listed in this section are required by TennCare and must be completed for a successful Attestation. A link with the forms required for Attestation is available on the left side of the screen.

➲All forms must be signed and dated within 90 days of the date you submit your attestation.

- Signature Page – A new Signature Page must be signed each year and it must be the most current version in use.

TennCare has two additional forms that affect only Nurse Practitioners (NPs) and Physician's Assistants (PAs) practicing in an FQHC or RHC.

- For NPs, we are asking for information about the doctor or other proctor, including the Group NPI, under which the NP is submitting claims. While TennCare allows this billing procedure, not knowing this information makes it difficult to us to verify patient encounter volume.

- PAs are eligible to participate in the EHR incentive program if they work in a PA-led FQHC or an RHC so led by a PA. (See FAQs for more information.) TennCare is now requiring information about the FQHC/RHC (name, address, and a copy of the letter indicating the status of the facility as that of an FQHC or RHC) and the name

and NPI of the lead PA. **All** PAs in an FQHC or RHC are eligible to participate if their facility is led by a PA.

See Section 3.4 on how to add a document.

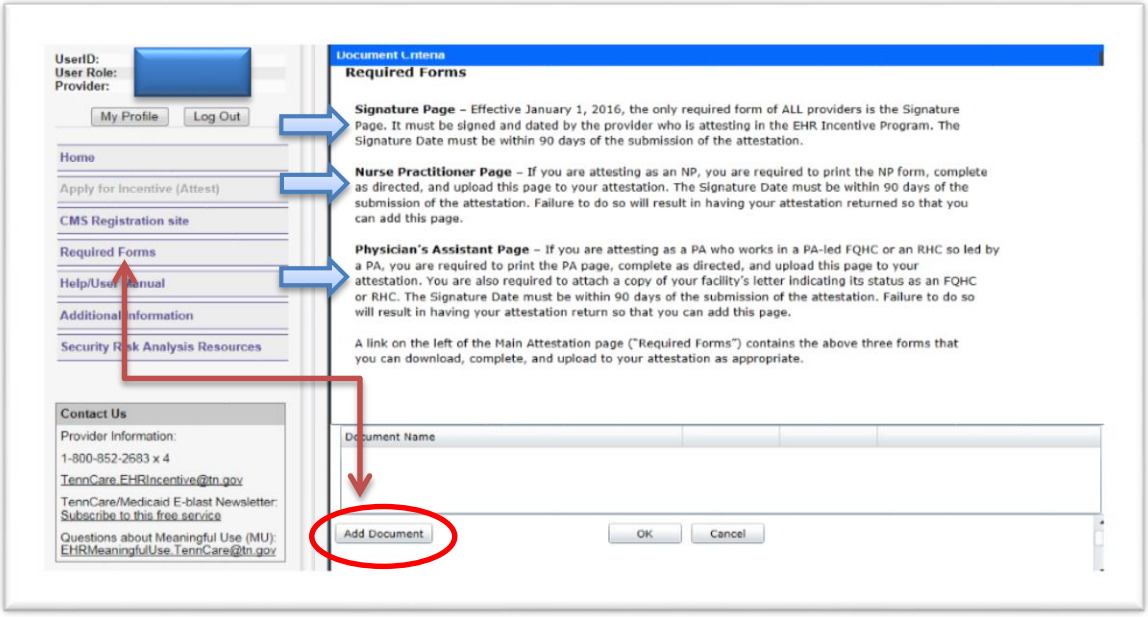


Figure 27 - EP Required Forms

4.1.4 Patient Volume Questions

Please see Figures 28, 29, and 30.

See the discussion on what is a patient encounters under "Patient Volume" in Section 4.1 above. If you still have questions, send an e-mail to TennCare.EHRIncentive@tn.gov.

- Enter the beginning date for the 90-day Patient Volume qualifying period in the preceding calendar year. (Figure 28) The end date of the 90-day qualifying period is auto-calculated for you. (Note: Your 90-day period cannot begin prior to January 1 nor exceed December 31.)
  - Begin Date – MM/DD/YYYY
  - End Date – MM/DD/YYYY (auto-calculated)

- What is the total number of patient encounters within the selected 90-day period?
  - Enter the TOTAL patient encounter count for the selected 90-day period. This number is also referred to as the Patient Volume denominator.

- What is the total number of Medicaid encounters (or Needy Individual encounters if applicable) for the selected 90-day period?
  - Enter the total Medicaid encounter count (or the Needy Individual count if applicable) for the 90-day period. This number is also referred to as the Patient Volume numerator.
    - **Counting OB/GYN encounters**

- TennCare MCOs only report the global encounter code when the child is born. Therefore, only one (1) encounter is reported to TennCare for the provider and not the prenatal or postnatal visits. This is the same process used by the majority of commercial insurance carriers.
- When reporting OB/GYN encounters for the purpose of the EHR attestation program EPs should only report one encounter for each child delivered during the 90-day qualifying period. EPs would then add to that total, the number of other office visits for which patients are seen, such as check-ups, infections, injuries, etc. Prenatal or postnatal visits, to be billed under the global encounter code, are **not** to be counted or reported during the 90-day qualifying period. (See FAQ IV for an example)

- Percentage of patient encounters over the selected 90-day period that were Medicaid, (or percentage of Needy Individuals (if applicable)):
  - This percentage is automatically calculated using the numerator and denominator entered above. If the calculation is less than 30%, or 20% for pediatricians attempting to qualify under the lower threshold, PIPP will not allow you to proceed with your attestation.

- Are any of your Medicaid patients covered by another state's Medicaid program? (Figure 29)
  - Yes – The state, patient count and your Provider Medicaid Number for each state must be entered, **starting** with Tennessee
  - No

- Does your 30% Patient Volume encounters include Needy Individuals? (If applicable) **Note:** This question will only appear if you previously indicated that you practice primarily in an FQHC or RNC. (Figure 30)
  - Yes – Enter the following counts:
    - TN Medicaid (TennCare)
    - CHIP (Title XXI)
    - Uncompensated
    - No Cost or Reduced Cost
  - No

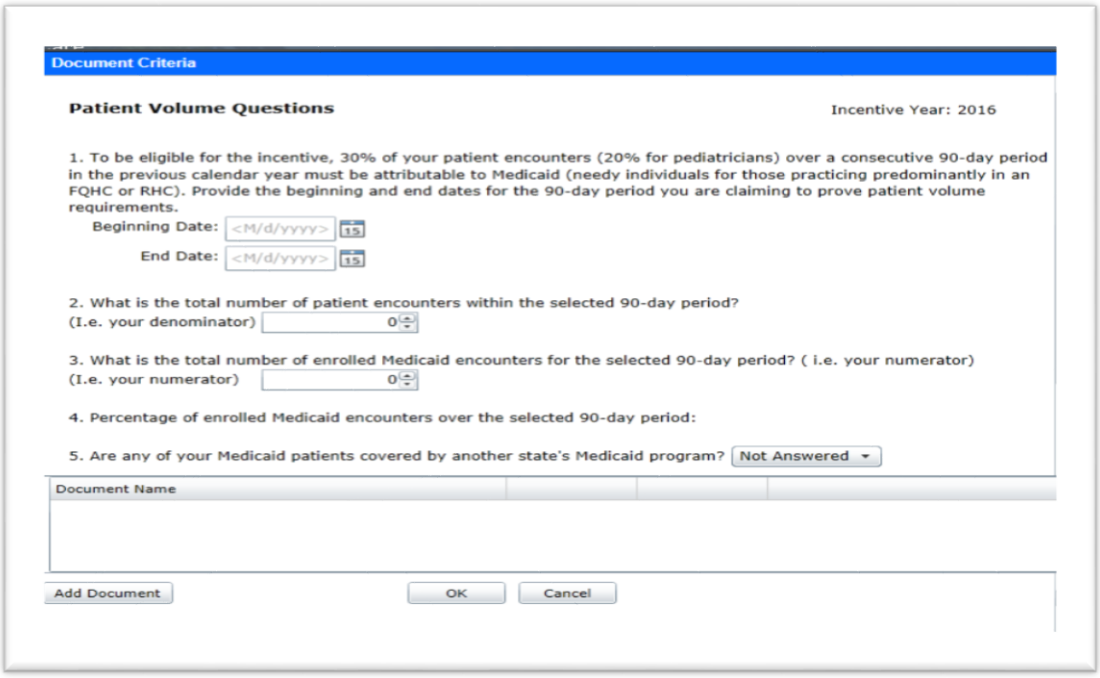


Figure 28 - EP Patient Volume - 1

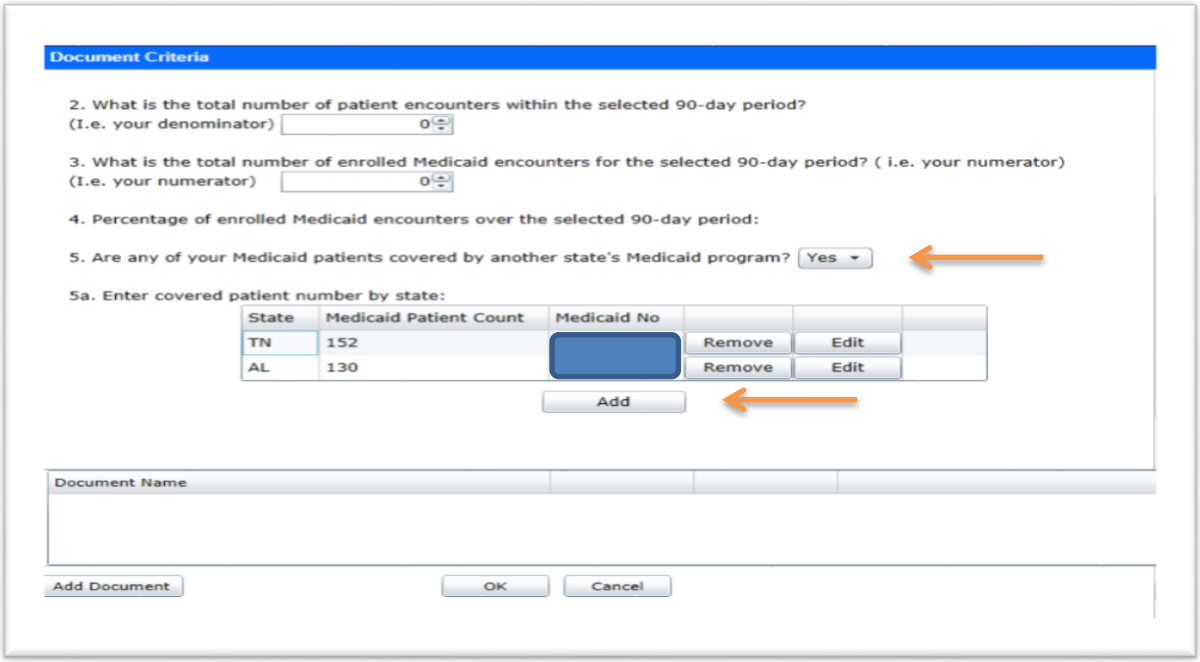


Figure 29 - EP Patient Volume - 2 Other State Coverage

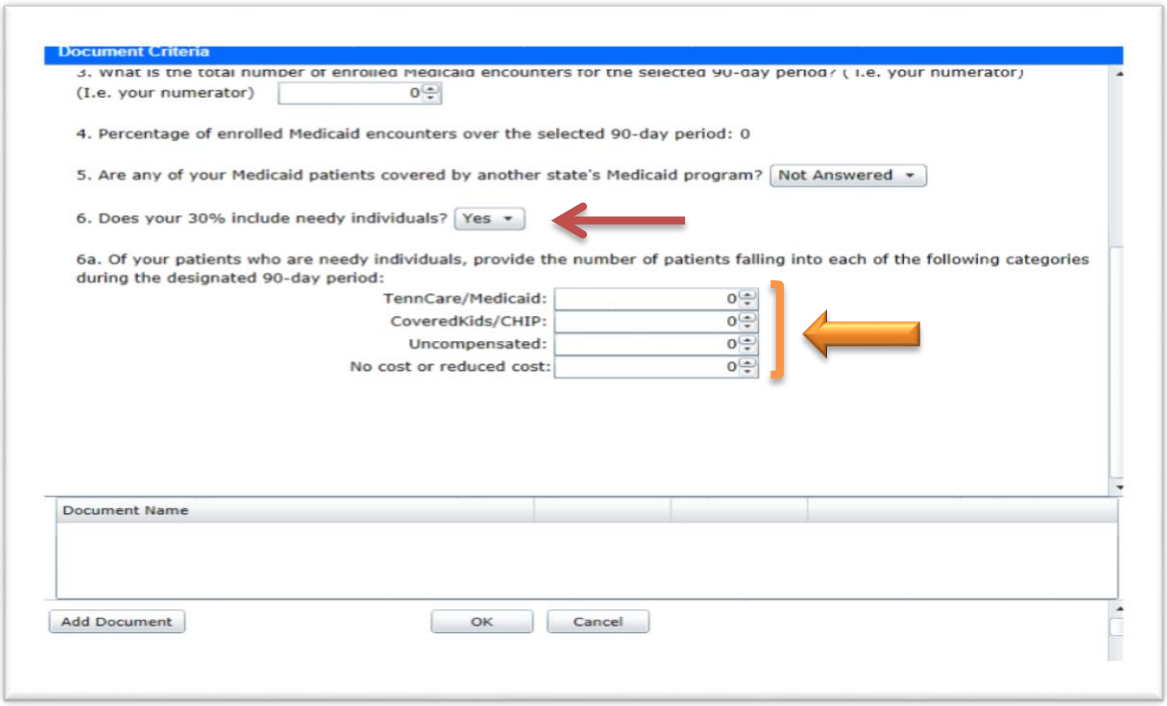


Figure 30 - EP Patient Volume - 3 Needy Individuals

Note: If you are doing Meaningful Use Attestation, you will have to complete the two MU pages prior to submitting your attestation. See Section 4.3 for information about attesting for MU.

4.2 Submit Attestation for Review

Once all Attestation links have been completed, the 'Attested?' column on the far right will display 'Yes' for all rows.

When you complete attestation, a button will appear "Submit for Review." After clicking on that button, another box will then appear asking you to either agree or disagree with the statements listed in the box. (Figure 31) Please read the text thoroughly and select the appropriate statement. If you click "I Do Not Agree," your attestation will not be submitted. Clicking on "I Agree" will submit your information to TennCare.

Another box will appear indicating that your information has been successfully submitted. (Figure 32) Click on "Log Out" (upper left hand side) and you are done! If at any time you want to see the status of your attestation, return to the portal, log in, and the latest information will be available to you. (See Section 3.2)

Following submission, the first column will disappear and you will not be able to change the information you entered. If TennCare discovers a problem that requires your assistance to correct, your information will be returned to you and you will then be able to make changes.

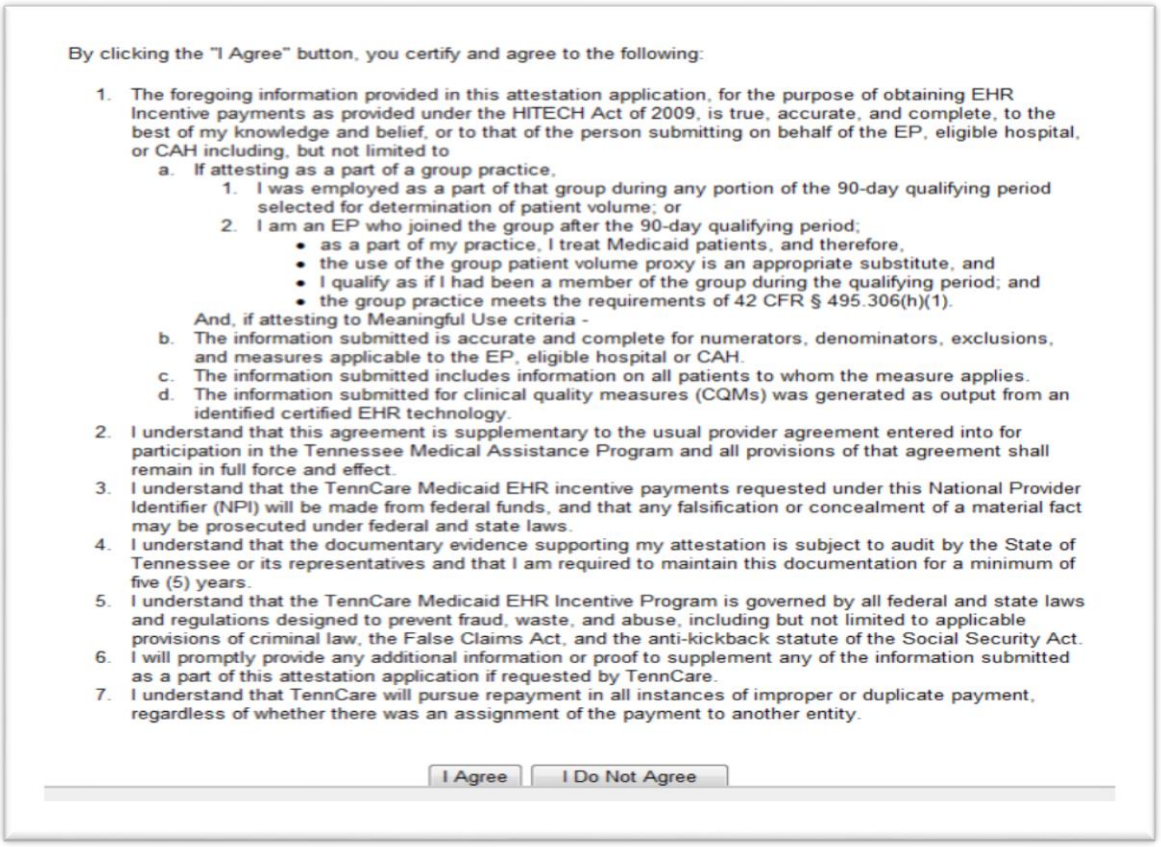


Figure 31- Attestation Submission – 1

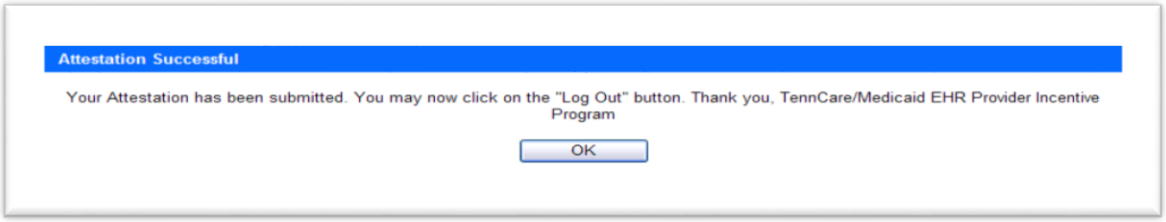


Figure 32 - Attestation Submission - 1

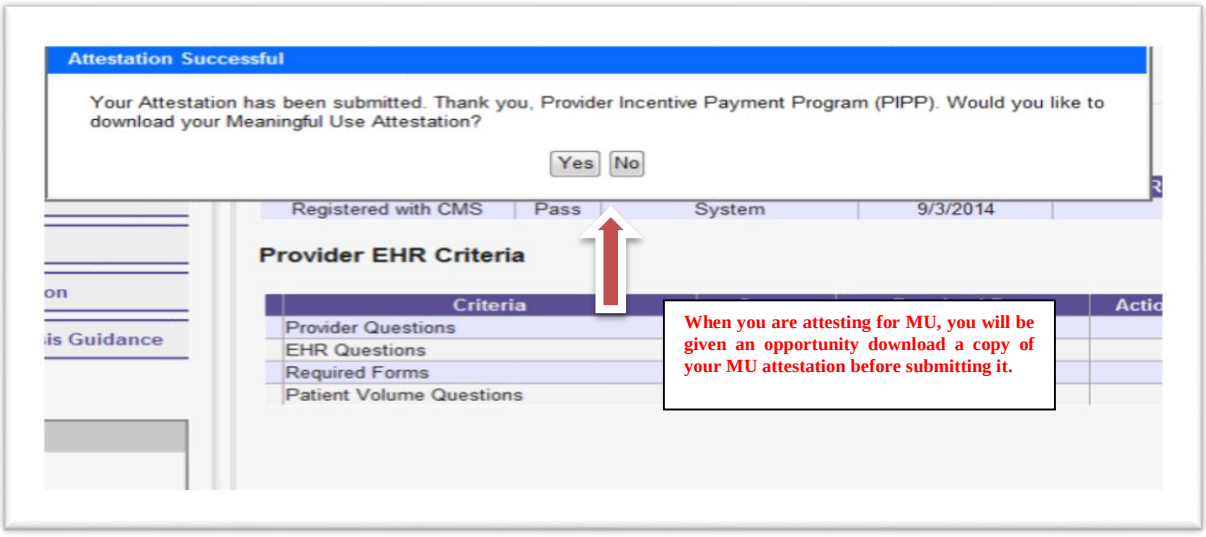


Figure 33 - Attestation Submission for Meaningful Use

4.3 Meaningful Use (MU) Attestation

Note: If you have questions or comments about this section, send an email to EHRMeaningfuluse.TennCare@tn.gov.

This section provides instruction for Eligible Professionals (EPs) attesting to Meaningful Use (Payment Years 2 – 6). Attestation for MU begins with answering the same questions as in Payment Year 1 and continues through the meaningful use criteria.

Under "Provider EHR Criteria", you will notice two new pages have been added. (Figure 34) These two pages are required when attesting for MU. They will only appear on the screen for MU Attestations. These pages are

- Meaningful Use Questions
- Meaningful Use Clinical Quality Measures

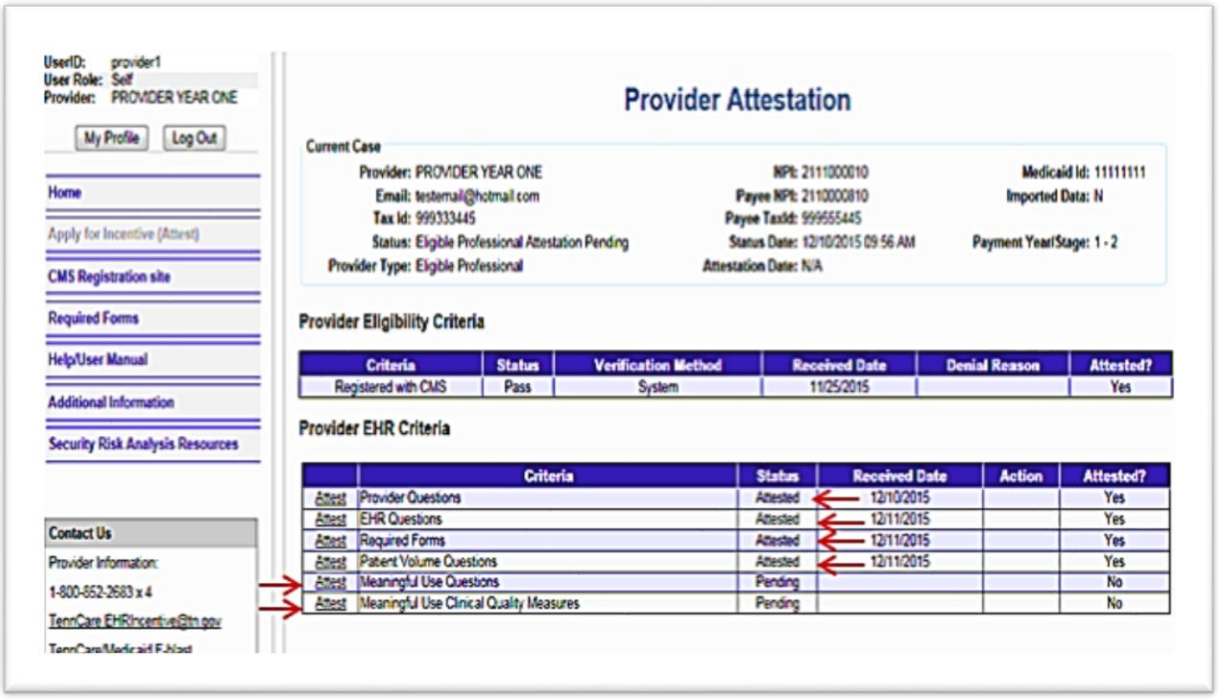


Figure 34 - EP Provider Attestation Screen

4.3.1 Initial & Subsequent Attestations

As shown in the figure above, EPs must answer the first four screens listed **each** year in which they attest. These screens are

- Provider Questions (See Section 4.1.1)
- EHR Questions (See Section 4.1.2)
- Required Forms (See Section 4.1.3)
- Patient Volume (See Section 4.1.4)

As stated above, for an MU Attestation, two additional screens must be completed for the second through the sixth year attestations.

4.3.2 Meaningful Use Questions

All EPs are required to attest to a single set of 10 Modified Stage 2 MU objectives. This replaces the Core and Menu structure of the previous stages. In 2015, there are some alternate exclusions and specifications available to accommodate providers scheduled to demonstrate MU Stage 1. In addition to the MU questions, this screen will allow the selection of the EHR MU Reporting Period and present a short series of General Questions. To begin attesting for the MU questions, click the 'Attest' link next to Meaningful Use Questions on the Provider Attestation page (Figure 34). This will open the window to begin attesting to the MU questions (Figure 35).

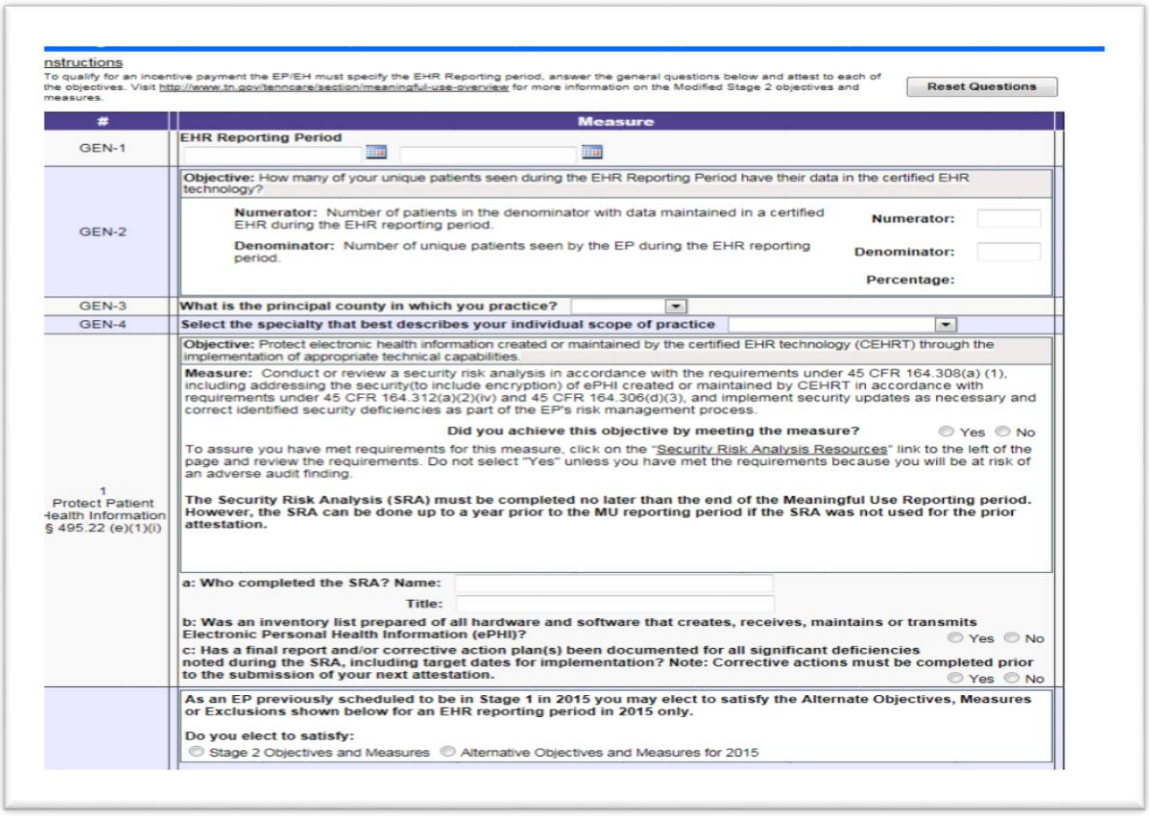


Figure 35 - EP MU Questions

4.3.2.1 General Questions

The MU questions begin with a short series of questions to ensure EPs have met CMS general requirements for participation in the EHR Incentive Program. Those general requirements are:

- More than 80% of the unique patients must have their data in a Certified EHR during the EHR reporting period.
- At least 50% of all encounters for providers who report multiple locations must take place at a location with certified EHR technology.

4.3.2.1.1 Selection of the EHR MU Reporting Period

- Select the beginning date for the EHR MU Reporting Period. (Figure 36) The date can be entered (MM/DD/YYYY) or selected from the drop-down calendar. The end date is automatically calculated for you. The first time a provider attests for MU, the MU reporting period is a consecutive 90-day period in the program year for which you are attesting. Before beginning the data entry process, check to make sure the reporting period from your EHR matches the attestation portal reporting period dates when entering the 90-day reporting period. **Ensure the EHR is generating data for 90 consecutive days, not the same date in January to the same date in April.** For providers who have already successfully demonstrates at least one year of MU, the next attestation period is for a full calendar year (January 1 – December 31).
  - Eligible providers who have yet to demonstrate (first timers) MU can utilize a 90 consecutive day reporting period in 2015-2017.

- **There are two exceptions: (a)** All EPs regardless of their stage or years of participation can use any continuous 90-day reporting period **in 2015**; and **(b)** any EP that choses to demonstrate Stage 3 in 2017 will have a 90-day reporting period in 2017.

Please note: the reporting period used for Clinical Quality Measures (CQMs) can be different from the MU Questions reporting period, but it must come from the same reporting year.

- The required EHR MU Reporting Period is subject to the following rules:
  - **Payment Year 2**: For most EPs, the first year MU is the second payment year of the EHR Incentive Program. The first year of TennCare MU requires a consecutive 90-day reporting period. The second year and beyond is the calendar year, unless the participant chooses to attest to Stage 3 MU in 2017. Providers attesting to Stage 3 MU in 2017 will have a 90-day reporting period (see above). Beginning in 2015, all providers will attest to Modified Stage 2 objectives. In 2017, providers will have the option to progress to Stage 3. All other providers will begin Stage 3 in 2018. The MU data reporting period is a full calendar year for all providers in 2018.
  - **Payment Years 3-6**: The EHR MU Reporting Period is the calendar year. The reporting period cannot begin prior to January 1 nor end after December 31.

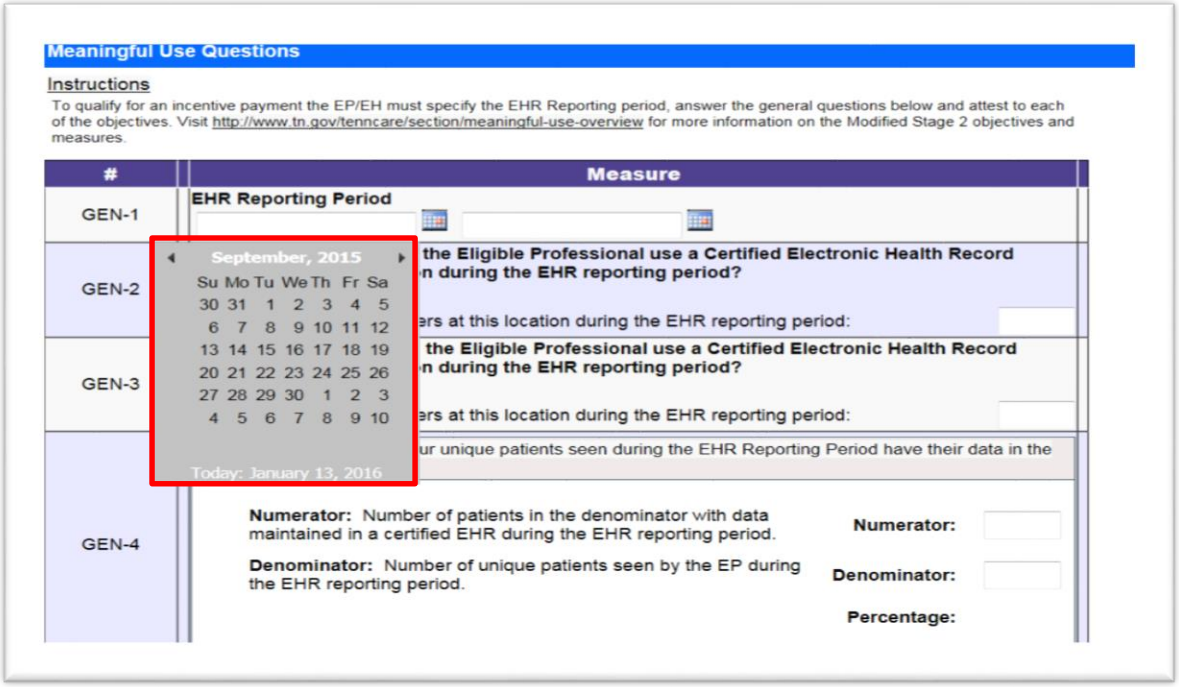


Figure 36 - EP EHR MU Reporting Period

4.3.2.2 Other General Questions

- **General Question-Multiple Sites** (Figure 37) – For providers who work at multiple sites, at least 50% of all their patient encounters must take place at a location with currently certified EHR technology.
  - For each location listed in Question 9 of the Provider Questions (See section 4.1.1)
    - Do more than 50% of your encounters take place at locations with Certified Electronic Health Record Technology (CEHRT)?
      - Select Yes/No radio button:
      - Enter the number of patient encounters at each location during the EHR reporting period.
    - If the EP has a location **without** CEHRT the EP must calculate:
      - Numerator: Number of encounters at all of the locations with CEHRT
      - Denominator: Total number of encounters at all of the locations (The calculated percentage must be greater than 50 %)

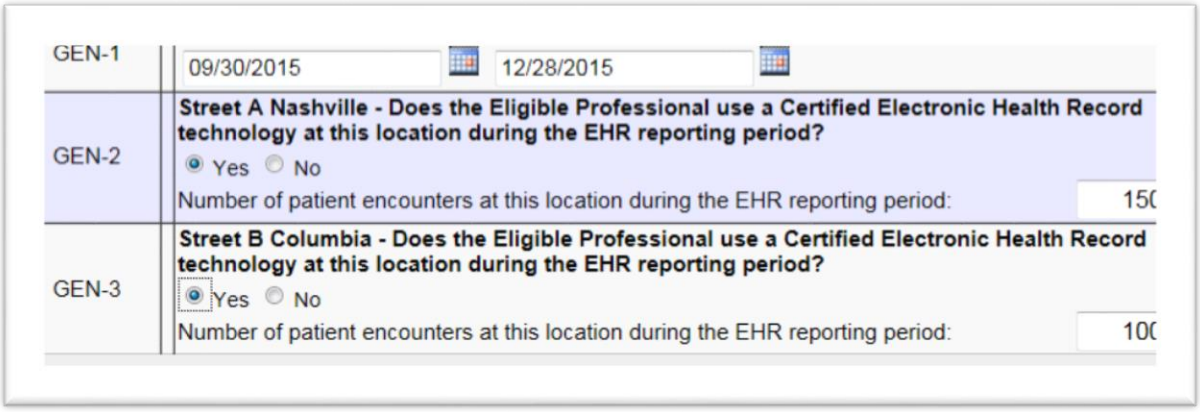


Figure 37 - EP General Question 1 - Multiple Locations

- **General Question-Unique Patients** (Figure 38) – Eligible providers must attest that at least 80% of unique patients have their data in the certified EHR during the EHR reporting period. Enter a numerator and denominator.
  - Numerator: Number of patients in the denominator with data maintained in a certified EHR during the EHR reporting period
  - Denominator: Number of unique patients seen by the EP during the EHR reporting period

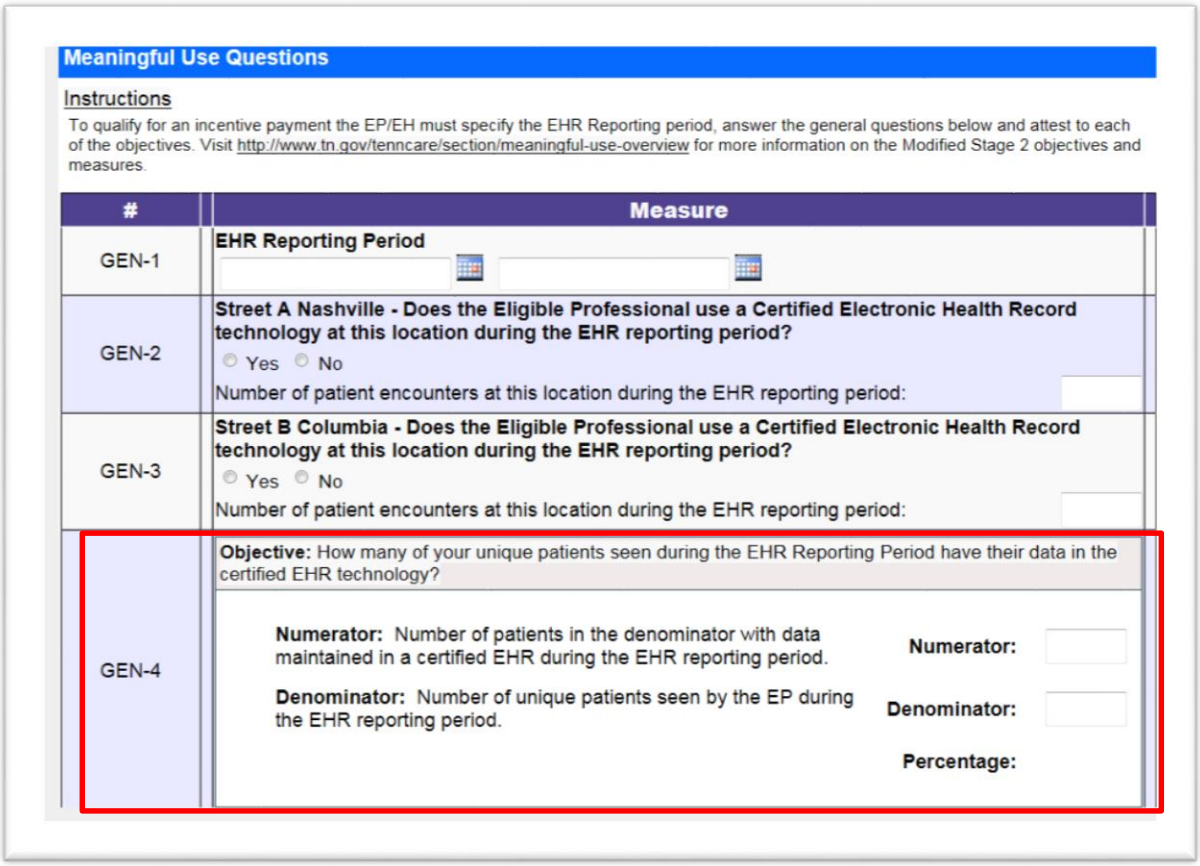


Figure 38 - EP General Question 2 - 80% of Unique Patients

- **General Question-Principal County** (Figure 39) – To aid TennCare in the analysis of MU data on a regional basis, TennCare is requiring the eligible provider to enter the primary county in which he/she operates. Select the county from the drop-down box provided.

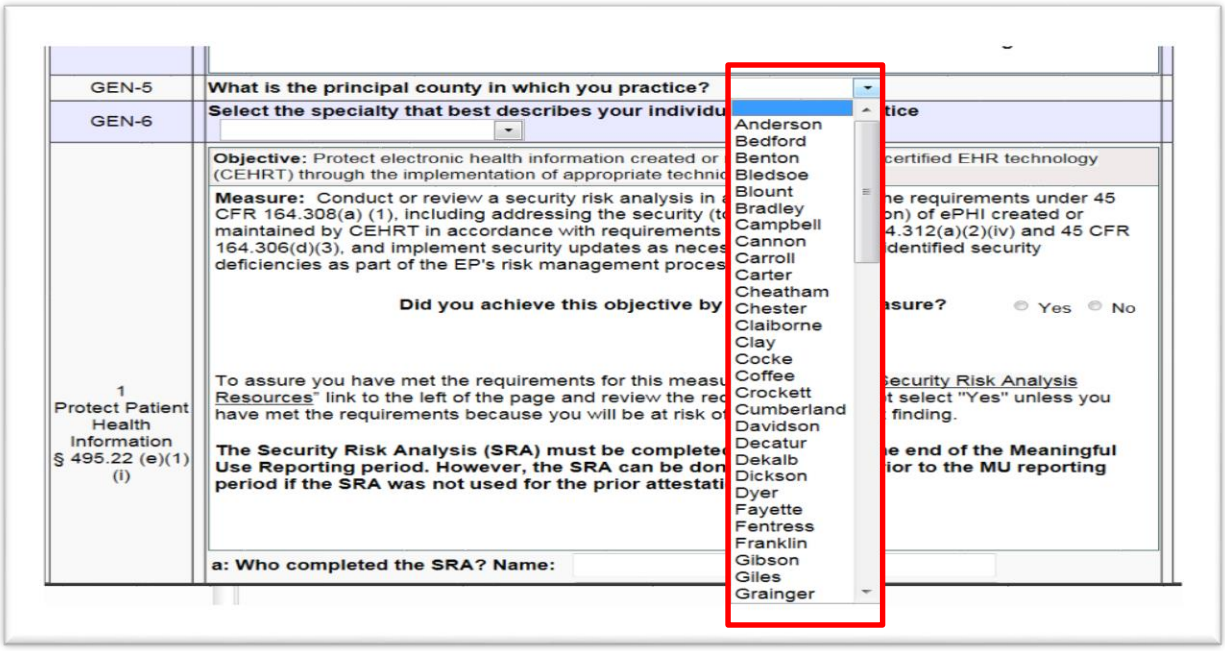


Figure 39 - Selection of Principal County

- **General Question-Provider Specialty** (Figure 40) – To aid TennCare in the analysis of MU data based on provider specialty, EPs with a provider type of Physician or Nurse Practitioner will be asked to select the specialty that best describes their practice. Certified Nurse Midwives will not have the option to select a specialty.

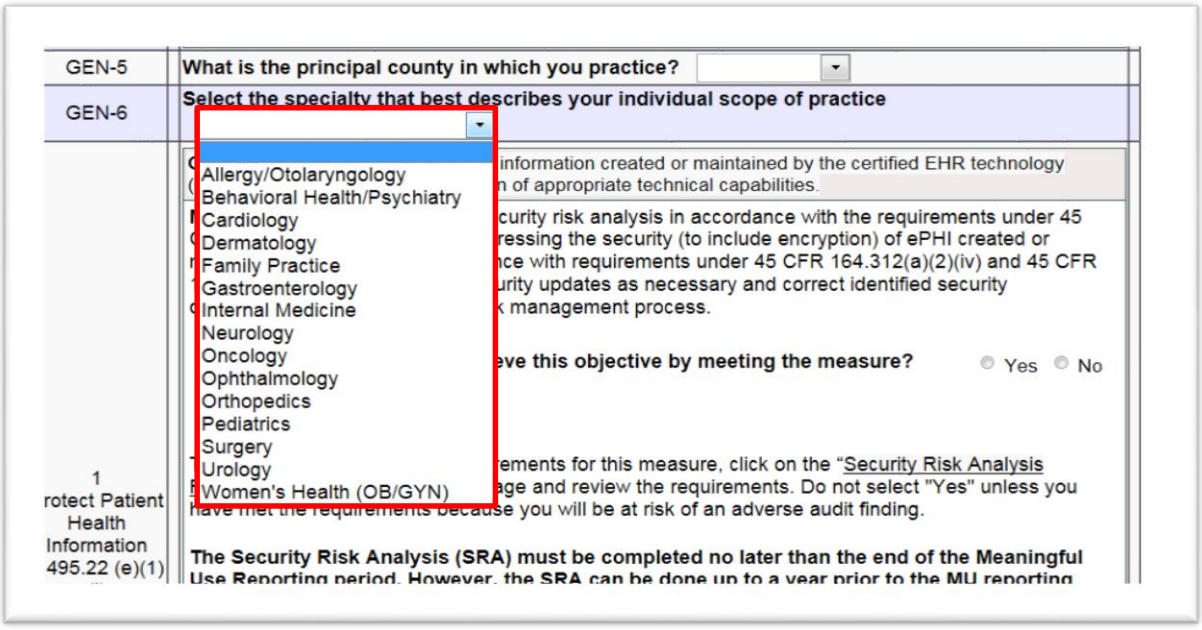


Figure 40 - Selection of Provider Specialty

4.3.2.3 MU Objectives/Measures

The EP must attest to 10 MU objectives including one consolidated public health reporting objective for Modified Stage 2. Attestation for most measures is accomplished by entering numerator, denominator, and exclusion information. Certain measures do not require a numerator and denominator. These measures require a Yes/No answer, and are marked as such. Providers may also be asked specific details regarding a particular measure. All fields are required to submit the attestation for review.

The screen for the MU questions displays the objective for each question and boxes to claim the exclusion, enter numerator and denominator, fill in the blank and/or answer Yes/No as required. (Figure 41)

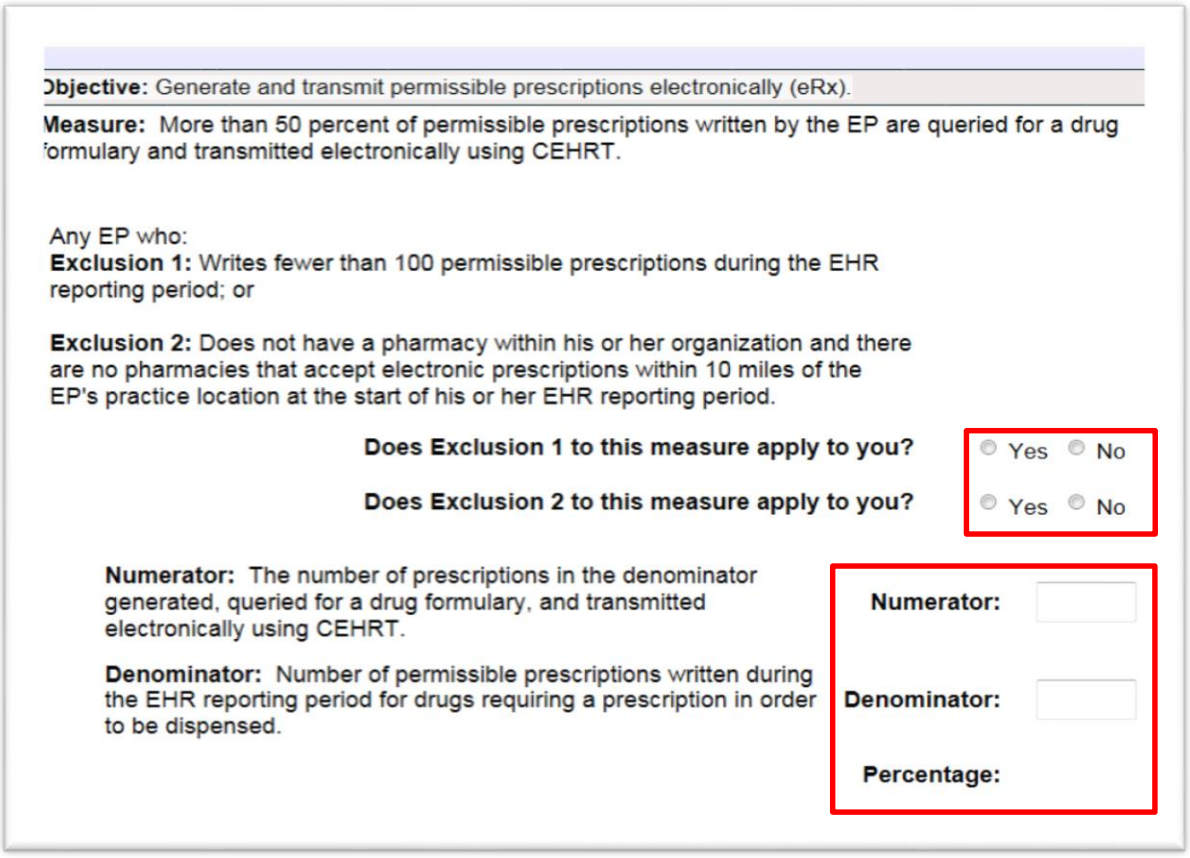


Figure 41 - Example MU Objective 4

Providers are required to complete some additional fields for Objective 1- Protect Patient Health Information. (Figure 42) Note: If the EP cannot answer "yes" to all questions the EP should stop to evaluate if they can meet the measure requirements.

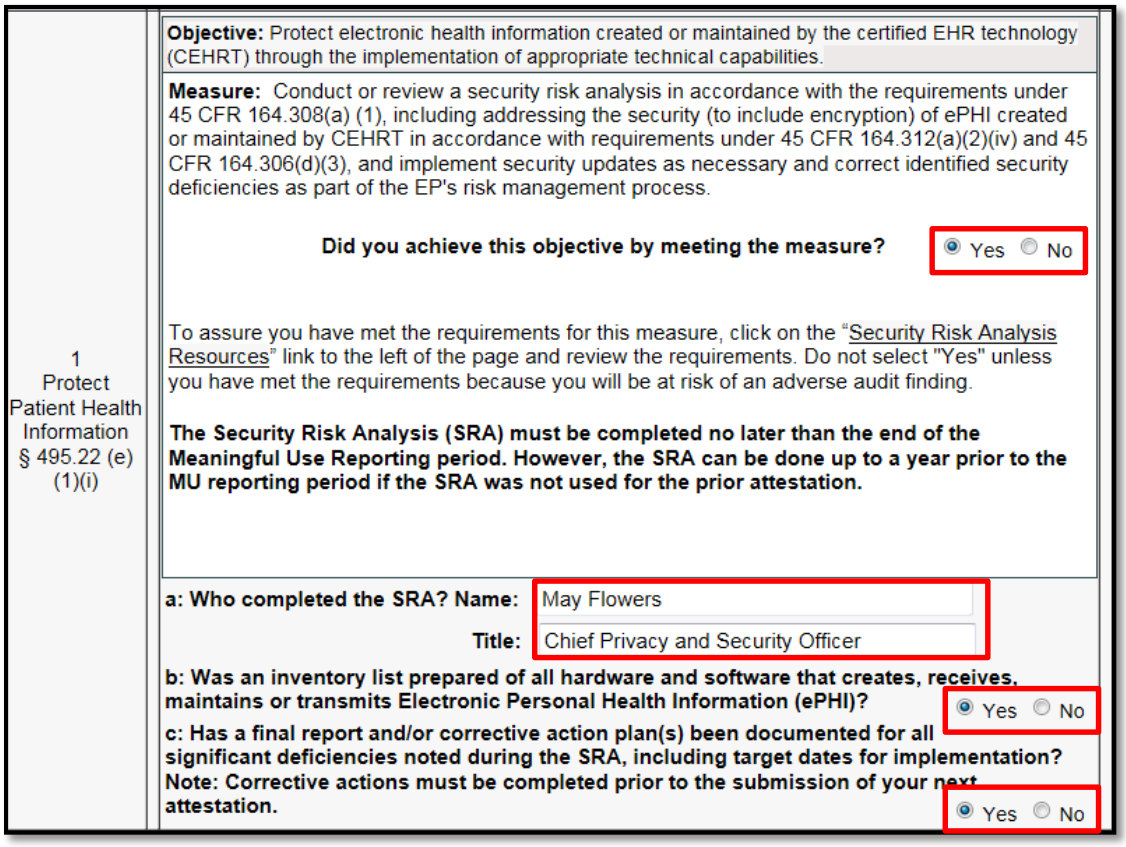


Figure 42 - Example of Additional Questions Required by Audit

Some objectives will have multiple measures in which the provider must attest. Measures that allow exclusions are indicated, and claiming the exclusion is attesting to that measure. (Figure 43)

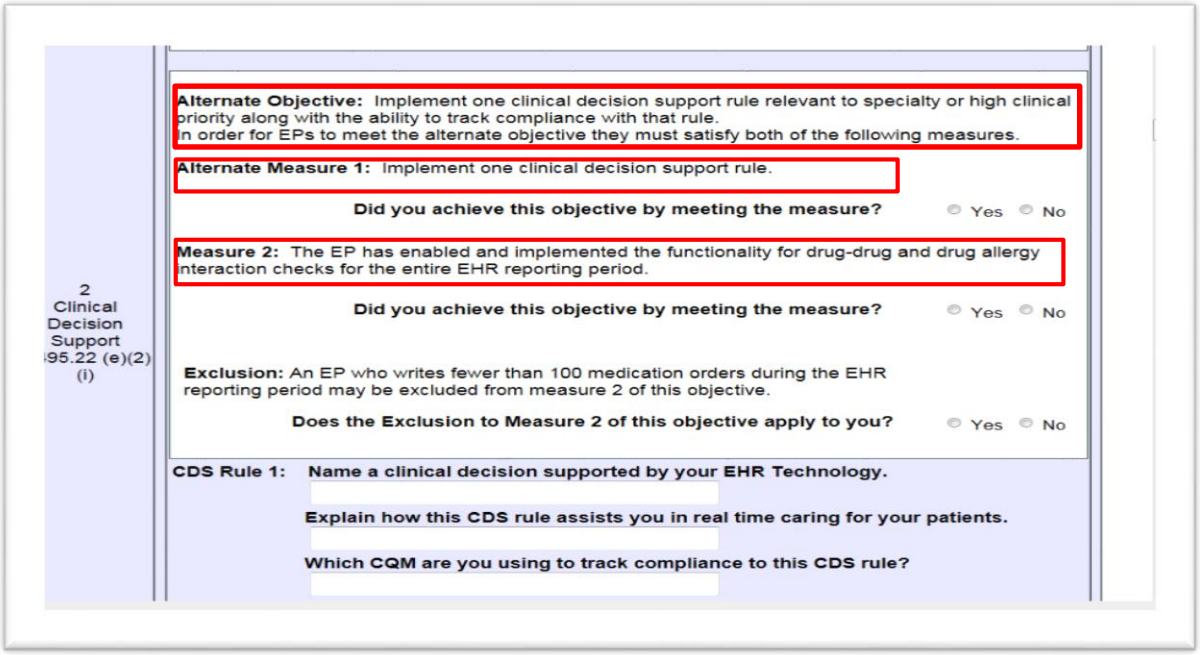


Figure 43 – Alternate Objective and Measure Example

For the 2015 EHR reporting period, alternate exclusions and specifications for certain objectives and measures are available for providers that were previously scheduled to be in Stage 1. Upon attestation, these providers will be offered the option to attest to the Modified Stage 2 objectives and measures, and the option to attest to the alternate specifications or claim the alternate exclusion, if available. (Figure 44)

Figure 44 – 2015 Option

For the Public Health objective, an EP can demonstrate meaningful use by using communications and information provided to a Public Health Agency (PHA) or a Clinical Data Registry (CDR). Providers attesting to PHA or CDR must identify the name of the PHA or CDR they are reporting to and identify the option in which they met the public health measure. (Figure 45)

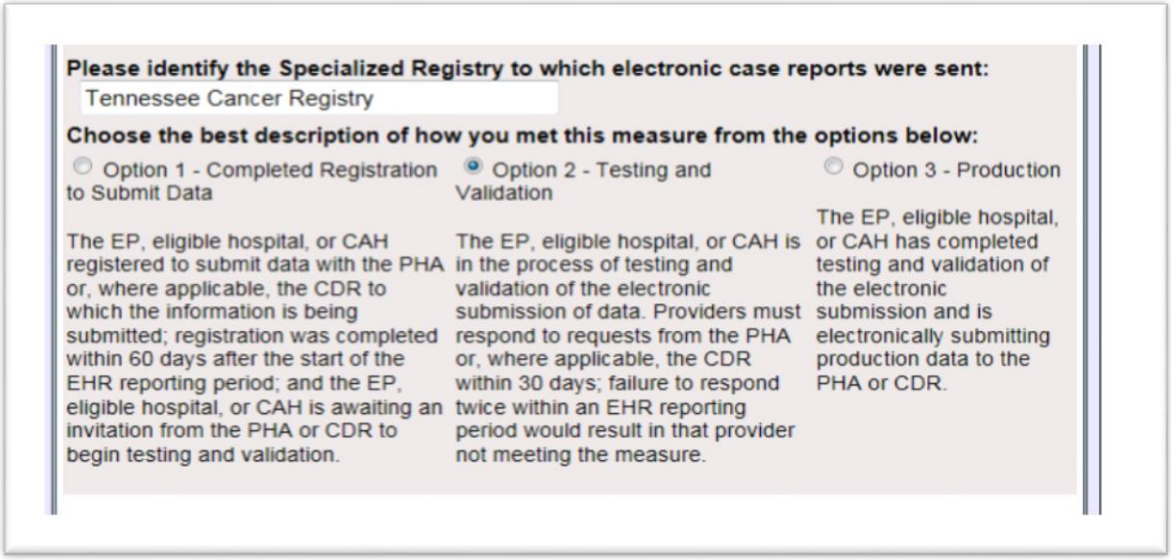


Figure 45 - Public Health Clinical Data Registry and Specialized Registry Reporting

4.3.2.4 Source for Denominator Data

Some questions require the provider to attest to whether the data for the denominator was obtained from ALL patient records or just those that are maintained using EHR technology. The provider must select the radio button, which indicates the source of the denominator. (Figure 46)

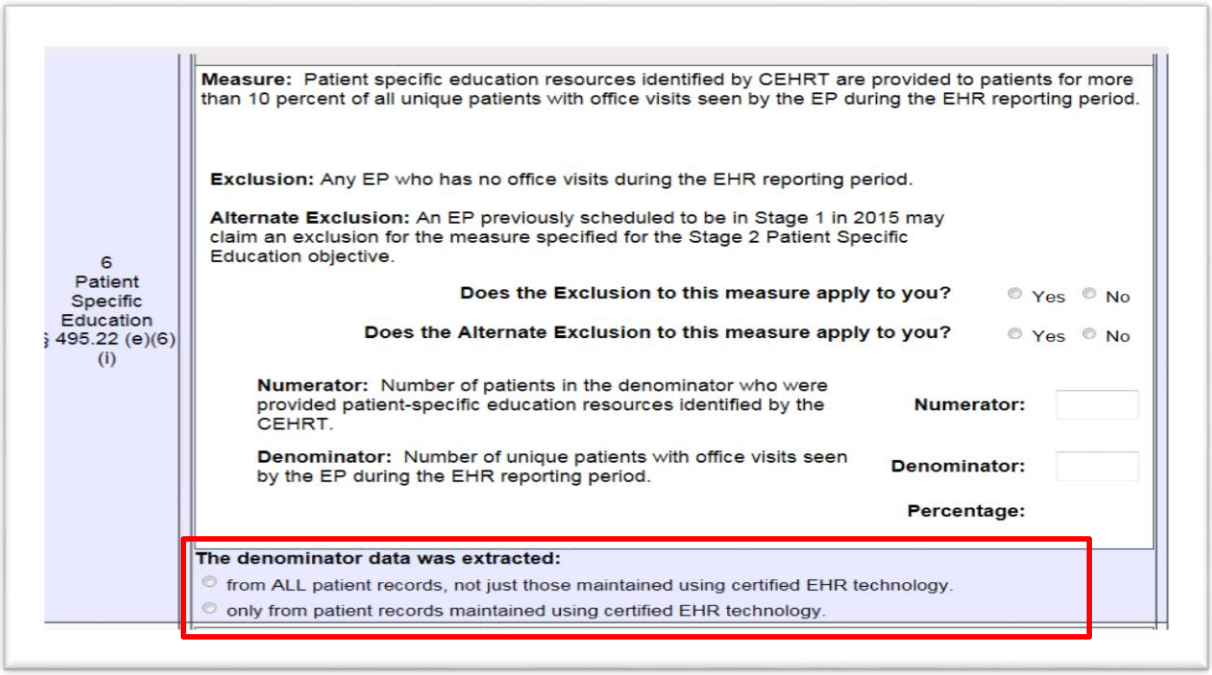


Figure 46 - Select Source for Denominator Data

4.3.2.5 Additional Screen Functions

At the bottom of the MU Questions screen are buttons that provide additional functionality (Figure 47).

- **Add Document** – The system provides the ability for the provider to submit additional documents to support their attestation. Submission of additional documentation is not required but doing so may speed up the review and approval process for receiving incentive payments. Please be sure that upload documentation supports your attestation because it will be carefully evaluated. See Section 3.4 about how to add a document. **It is never appropriate** to upload documents containing Personal Health Information (PHI) and any documents containing PHI will be deleted from the portal.
- **OK** – Clicking the OK button completes this attestation screen. The system will automatically check to ensure that all objectives and measures are attested to and alert the provider of any missed items. Once all deficiencies are corrected clicking OK will save all answers and return to the Provider Attestation screen.
- **Save and Exit** – Clicking the save and exit button allows the provider to save their work and return to the attestation later. The provider will be returned to the Provider Attestation page.
- **Cancel** – Clicking cancel will return the provider to the Provider Attestation page. NOTE: Any data entered in the current session will NOT be saved.

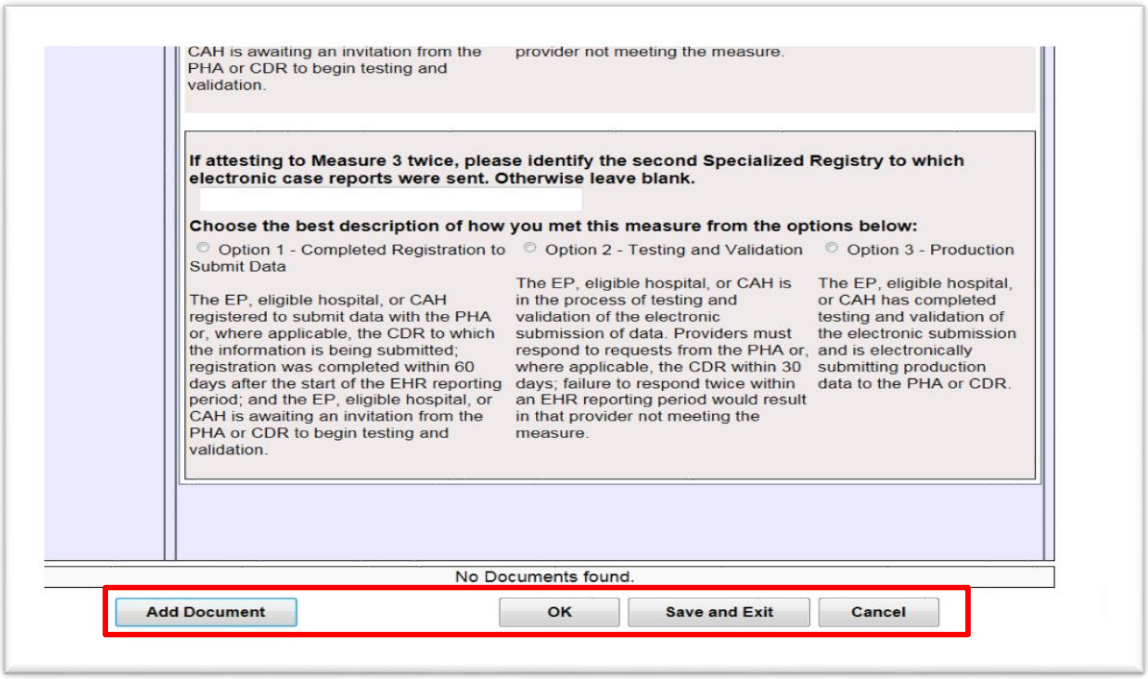


Figure 47 - EP Additional Screen Functions

4.3.3 Clinical Quality Measures

To qualify for an incentive payment for MU, the EP must attest to at least 9 CQMs. Each EP is encouraged to report on 9 Recommended Core CQMs for the adult population or 9 Recommended Core CQMs for the pediatric population, if the CQMs are applicable to their scope of practice. Selected CQMs must cover at least 3 of the National Quality Strategy domains. (Figure 48) At the bottom of the screen, select the radio button that is applicable to your practice.

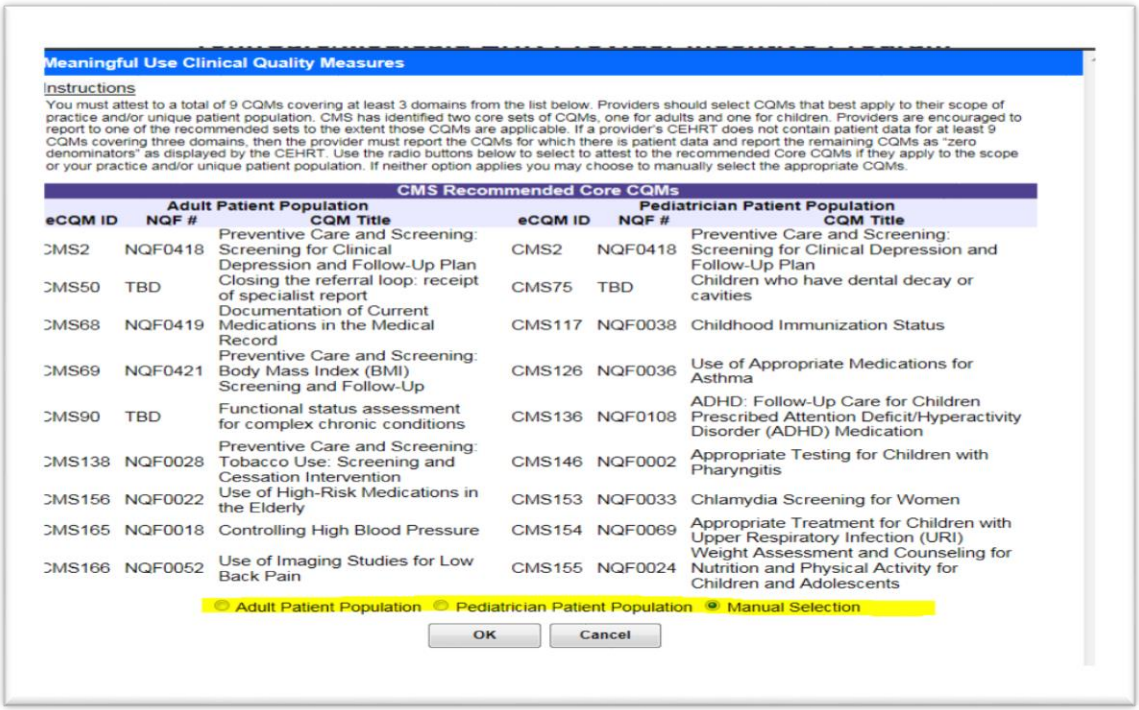
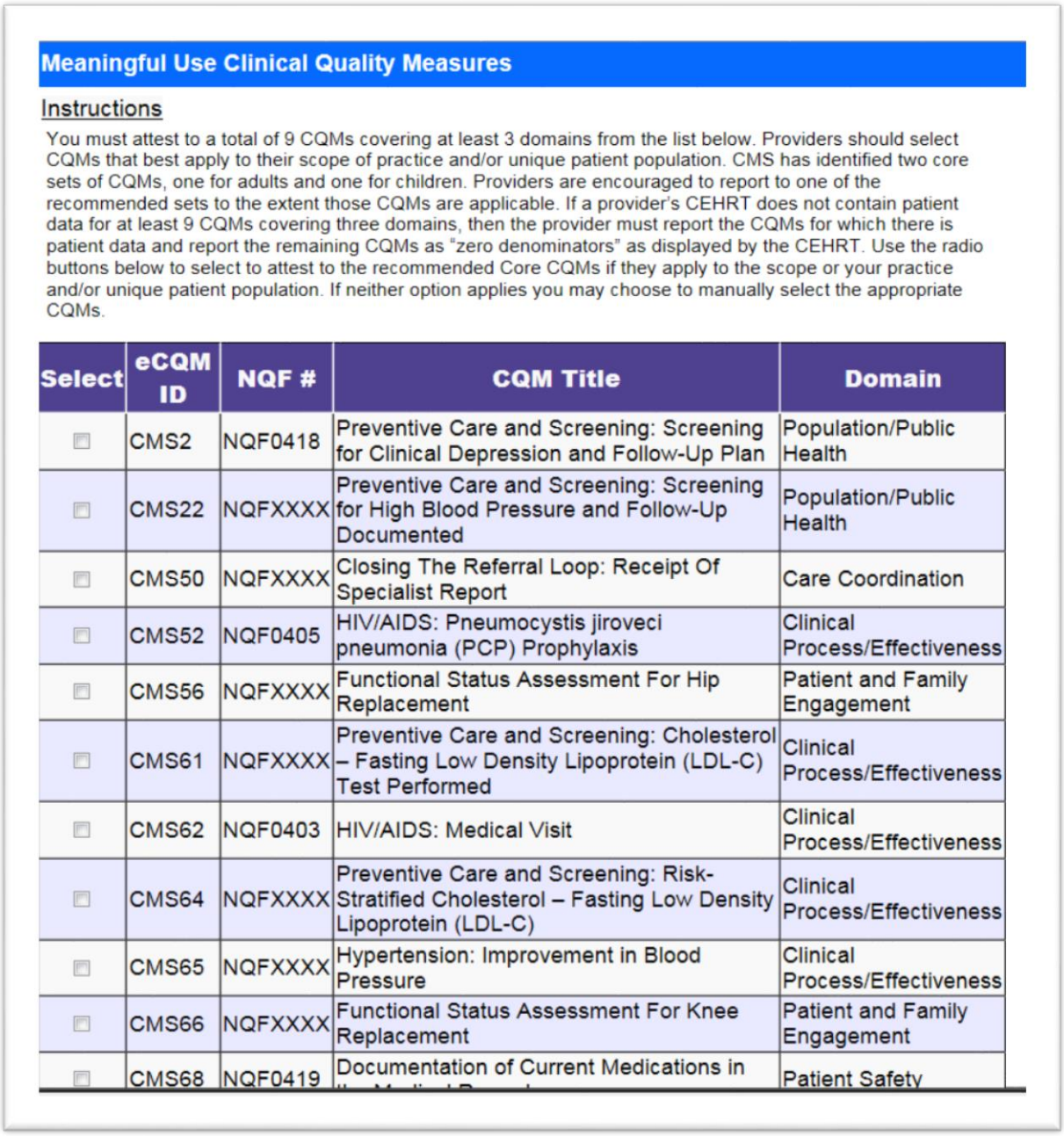


Figure 48 - EP Recommended Adult and Child CQM Screen

- Specialist EPs can also manually select 9 CQMs that apply to their scope of practice if the recommended set is not applicable. (Figure 49) Selected CQMs should cover at least 3 of following domains: Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Health Resources and Clinical Processes/Effectiveness. (Figures 49 and 52)



Meaningful Use Clinical Quality Measures

Instructions

You must attest to a total of 9 CQMs covering at least 3 domains from the list below. Providers should select CQMs that best apply to their scope of practice and/or unique patient population. CMS has identified two core sets of CQMs, one for adults and one for children. Providers are encouraged to report to one of the recommended sets to the extent those CQMs are applicable. If a provider's CEHRT does not contain patient data for at least 9 CQMs covering three domains, then the provider must report the CQMs for which there is patient data and report the remaining CQMs as "zero denominators" as displayed by the CEHRT. Use the radio buttons below to select to attest to the recommended Core CQMs if they apply to the scope or your practice and/or unique patient population. If neither option applies you may choose to manually select the appropriate CQMs.

Select	eCQM ID	NQF #	CQM Title	Domain
☐	CMS2	NQF0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health
☐	CMS22	NQFXXXX	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Population/Public Health
☐	CMS50	NQFXXXX	Closing The Referral Loop: Receipt Of Specialist Report	Care Coordination
☐	CMS52	NQF0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Clinical Process/Effectiveness
☐	CMS56	NQFXXXX	Functional Status Assessment For Hip Replacement	Patient and Family Engagement
☐	CMS61	NQFXXXX	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed	Clinical Process/Effectiveness
☐	CMS62	NQF0403	HIV/AIDS: Medical Visit	Clinical Process/Effectiveness
☐	CMS64	NQFXXXX	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	Clinical Process/Effectiveness
☐	CMS65	NQFXXXX	Hypertension: Improvement in Blood Pressure	Clinical Process/Effectiveness
☐	CMS66	NQFXXXX	Functional Status Assessment For Knee Replacement	Patient and Family Engagement
☐	CMS68	NQF0419	Documentation of Current Medications in	Patient Safety

Figure 49 - EP Manual Selection CQM Screen

- The system will present the EP with a grid of 64 CQMs. The provider must choose 9 by selecting the check box next to the CQM. The provider will then add the selected CQMs to the EP's attestation by clicking "OK". Failure to select at least 9 CQMs from 3 domains will prevent the provider from attesting. (Figures 50 and 51) Numerator, denominator and exclusion information must be reported directly from information generated by certified EHR technology for the additional CQMs.

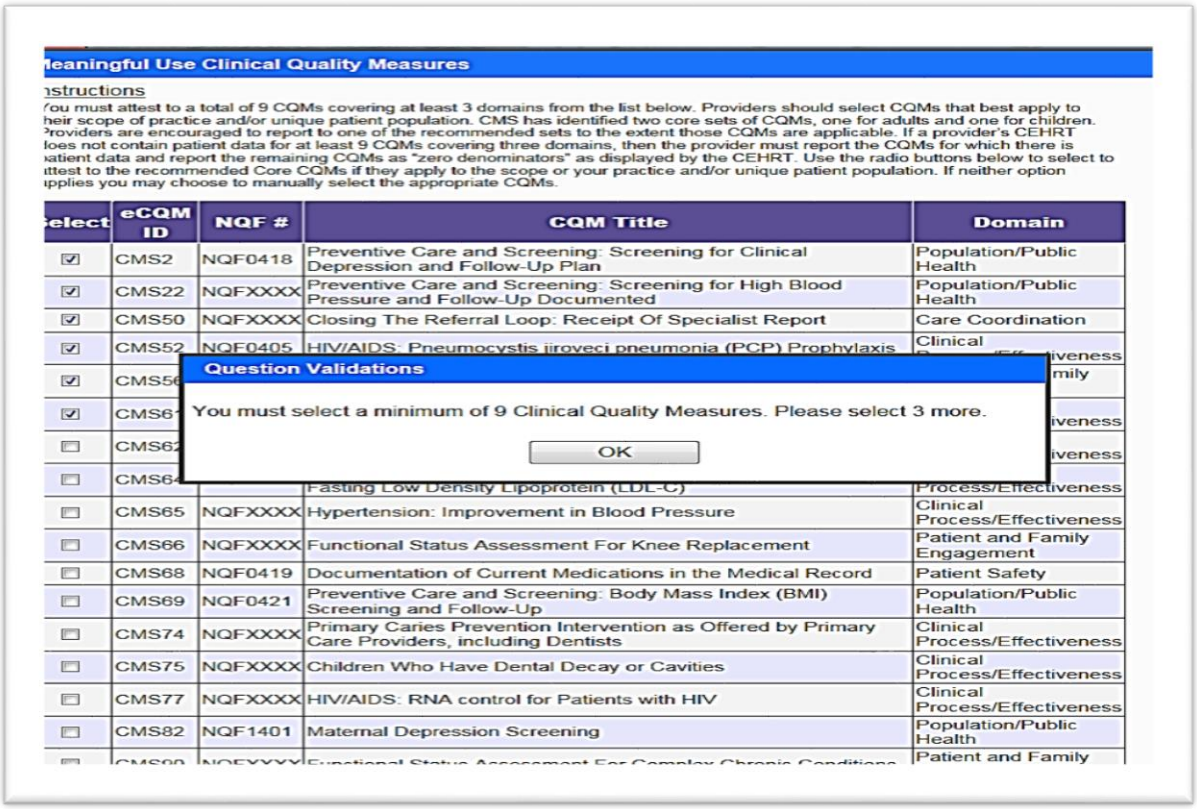
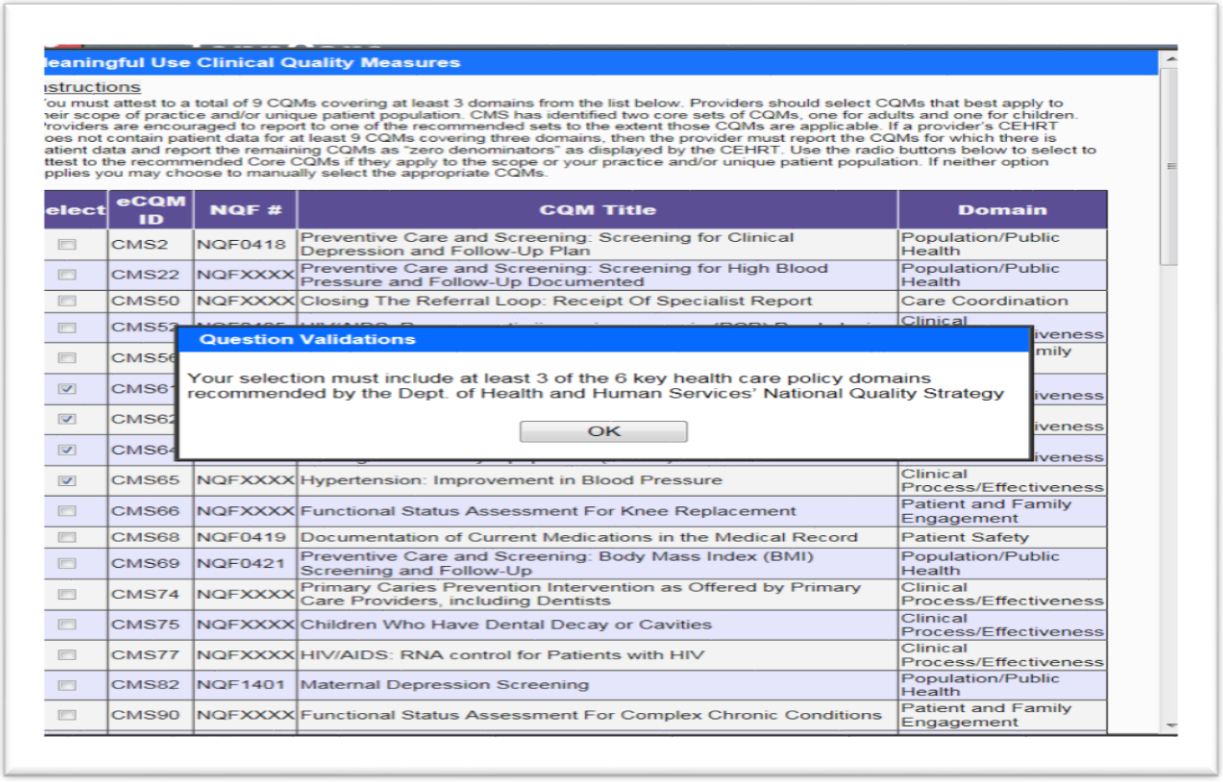


Figure 50 - CQM Selection Screen



elect	eCQM ID	NQF #	CQM Title	Domain
	CMS2	NQF0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health
	CMS22	NQFXXXX	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Population/Public Health
	CMS50	NQFXXXX	Closing The Referral Loop: Receipt Of Specialist Report	Care Coordination
	CMS52			Clinical
	CMS56			mily
	CMS61			iveness
	CMS62			iveness
	CMS64			iveness
	CMS65	NQFXXXX	Hypertension: Improvement in Blood Pressure	Clinical Process/Effectiveness
	CMS66	NQFXXXX	Functional Status Assessment For Knee Replacement	Patient and Family Engagement
	CMS68	NQF0419	Documentation of Current Medications in the Medical Record	Patient Safety
	CMS69	NQF0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Population/Public Health
	CMS74	NQFXXXX	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Clinical Process/Effectiveness
	CMS75	NQFXXXX	Children Who Have Dental Decay or Cavities	Clinical Process/Effectiveness
	CMS77	NQFXXXX	HIV/AIDS: RNA control for Patients with HIV	Clinical Process/Effectiveness
	CMS82	NQF1401	Maternal Depression Screening	Population/Public Health
	CMS90	NQFXXXX	Functional Status Assessment For Complex Chronic Conditions	Patient and Family Engagement

Figure 51 - CQM Selection Screen with Error Message

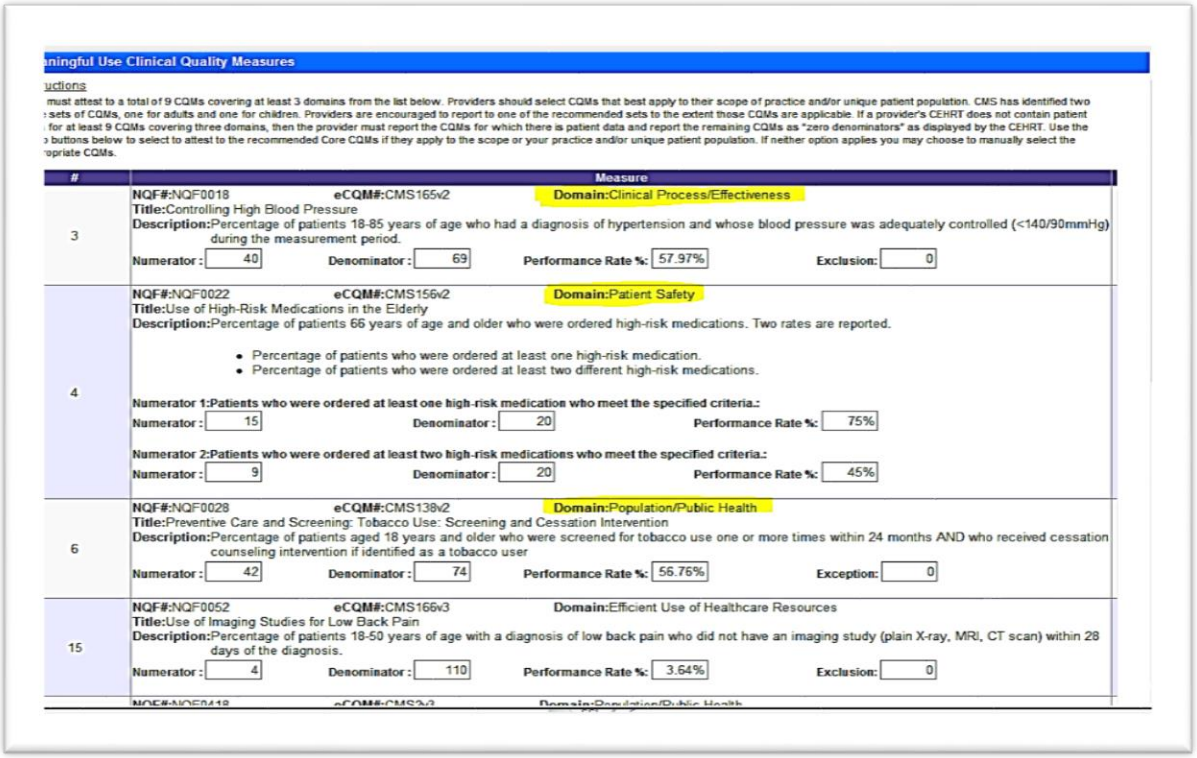


Figure 52 - CQM Domains

Functionality for Add Document, OK, Save and Exit, and Cancel function the same as the MU Questions screen. See Section 4.3.2.5 for details.

4.4 Submit Attestation for Review

Once you have completed the MU attestation screens, see Section 4.2 above on how to submit your attestation for review. Once eligibility, EHR certification and patient volume are verified, the attestation will be placed in Quality Review status. A standard set of criteria will be used to verify all MU Measures and CQMs. Your attestation may be returned to you with a letter stating outstanding issues, questions or requesting supporting documentation that must be resolved in order to receive payment. Address these questions and **re-submit as soon as possible**. If you need technical assistance, send a request via the ehrmeaningfuluse.tenncare@tn.gov mailbox.

5. Eligible Hospital (EH) Provider Attestation Instructions

Note: You are required to complete the appropriate pages for each year of attestation.

Note 2: If you have questions or comments about this section, send an email to TennCare.EHRIncentive@tn.gov.

This section provides instruction for EHs, whether attesting for the first time (Program Year 1), or for subsequent years. Unlike EPs, EHs (other than children's hospitals) can participate in both the Medicare and Medicaid EHR Provider Incentive Programs.

Because of the Medicare payment reductions, Dual EHs should attest first through Medi**CARE**. CMS will notify TennCare of the EH's passing the Meaningful Use (MU) attestation. In turn, TennCare will notify the EH to proceed with TennCare attestation. More about MU attestation will be found in Section 5.3 below.

CMS requires hospitals to continue attesting even after receiving all EHR Incentive Payments. The purpose of this requirement is to enable EHs from being assessed a Medi**care** payment adjustment in subsequent years.

The first four screens must be completed for **each** year in which you apply for an EHR Incentive Payment, including **all** documentation. These four screens are:

- Provider Questions
- EHR Questions
- Required Forms
- Patient Volume Questions

There is a fifth screen, "Payment Calculations", which is only completed when attesting in the **first year**. This information is used to calculate the EH's incentive payment for all three incentive payments. With CMS' approval, TennCare pays the hospital EHR Incentive Payment 50% for the first year, 30% for the second year, and 20% for the third year. The third year EHR Incentive Payment is made following an audit of the first two incentive payments to determine if TennCare has previously overpaid or underpaid the EH.

Clicking on 'Apply for Incentive (Attest)' link will display the Provider Attestation screen. Under the Provider EHR Criteria heading, attestation categories will be displayed. Begin attestation by selecting one of the 'Attest' links. (Figure 53)

Note:

Please be prepared to enter all required information upon entering the question screens. Once you have started to attest, the system will only save the data entered if there are no errors and all questions have been filled out completely. This includes uploading any required documentation. ***While you can stop and save information in the Meaningful Use Section without losing your information, information about CQMs cannot be saved.***

5.1 The Provider Attestation Home Page

Figure 53 shows an example of the Provider Attestation Home Page. After you complete the answers on each page, you will return to this page. The box provides some identifying information about the hospital. The status of the hospital's attestation as well as the date of the status reported is also given.

The **'Provider Eligibility Criteria'** section shows that the hospital has registered with CMS and the date the information was received by TennCare.

The **'Provider EHR Criteria'** section shows the Attestation questions that must be completed. You must respond to all of the questions on each page (click "Attest" in the first column). Once you have answered the questions on a page, click "OK" and you will return to this page. "Pend" will then appear in the first column. Up until you submit your information for review, you may go back and change your responses. Once you submit your attestation, you will not be able to change any information unless we return the attestation to you. The headings under this section are described below.

Criteria: Each page must be answered to apply for an incentive payment. Some of the information will be pre-printed.

- Provider Questions – Information about the hospital
- EHR Questions – Information about the hospital's certified EHR system/module(s); you will be asked to upload documentation that proves the hospital has or has access to a certified EHR system/module. This must be done for **each** year of the EHR Provider Incentive Program. If you change certified EHR systems, the box where you enter your CMS Certification Number is an editable field, after the first year. This means you can enter your new certification number here.
- Required Forms – You are required to upload a newly signed updated Signature Page each year (see the Required Forms link in the left column on the page). The Signature Page must be dated within 90 days of the submission of your attestation.
- Patient Volume – Submit information about the hospital's total patient encounters and total Medicaid encounters.

  Note: When talking about Medicaid and/or TennCare enrollees, providers should understand that this also applies to individuals enrolled in the Medicaid program of another state.

🕮 How is a Medicaid encounter defined?

A Medicaid encounter means services rendered to an individual per inpatient discharge where any of the following may apply

- TennCare paid for all or part of the services rendered
- TennCare paid for all or part of the individual's cost sharing
- The individual was enrolled in TennCare (or another state's Medicaid program) at the time the billable service was provided

A Medicaid encounter means services rendered to an individual in an emergency department on any 1 day where any of the following may apply

- TennCare paid for all or part of the services rendered
- TennCare paid for all or part of the individual's cost sharing
- The individual was enrolled in TennCare (or another state's Medicaid program) at the time the billable service was provided

So, what does "The individual was enrolled in TennCare at the time the billable service was provided" mean? Providers may now count claims denied under certain circumstances when counting patient encounters.

For example, if a claim was denied because it was filed late, or the service exceeded service limits, or it is a service not covered by TennCare, a provider may count that encounter when calculating patient volume. However, if the claim was denied because the individual was not enrolled in TennCare (or the Medicaid program of another state) on the date of service, that claim cannot be included as a patient encounter. Or if the provider was not enrolled as a Medicaid provider and contracted with at least one of TennCare's Managed Care Contractors (MCCs), then that claim could not be counted.

- Payment Calculations – Requires information from the hospital's JAR or CMS Hospital Report. **If using the CMS Hospital Cost Report,** you are required to upload Worksheets S-3 Part 1, S-10, and C Part 1 for the current year and prior years. As mentioned above, you will only complete this page the first time you attest in the TennCare EHR Incentive Program.
- **Status** – "Pending" will appear in this column until you complete each page. "Attested" will appear once each page will then appear.
- **Received Date –** This is the date that you completed a particular page.
- **Action –** If the attestation is returned to the provider to correct information or the attestation is denied, the reason will be shown here.
- **Attested –** "No" will change to "Yes" as you complete each page.

(See Section 5.2 on how to submit the attestation for review once every section is complete.)

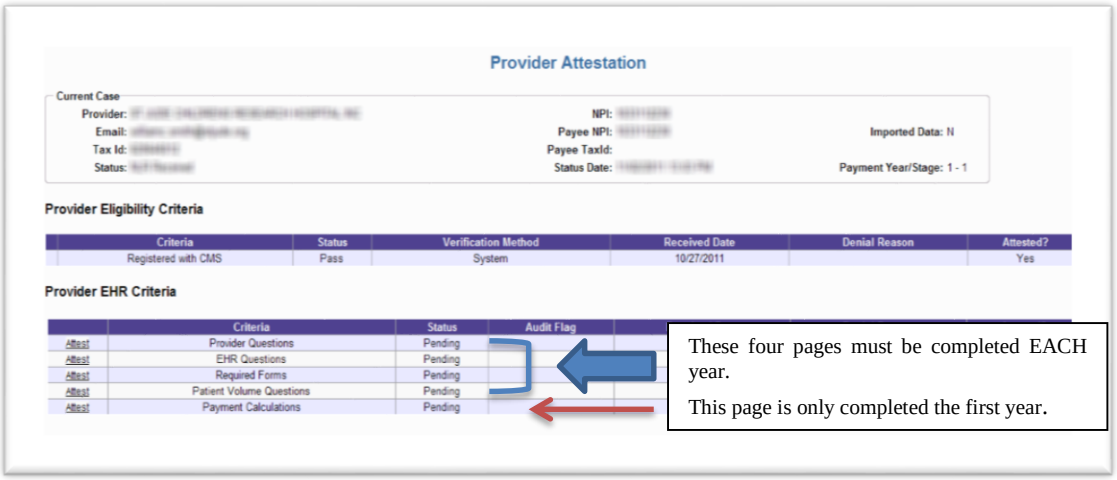


Figure 53 - Eligible Hospital Provider Attestation

5.1.1 Provider Questions

Please see Figure 54.

1. Type of hospital
   - Critical Access Hospital (CAH)
   - Children's Hospital
   - Acute Care Hospital
2. Ownership Type:
   - Private
   - State Owned
   - Non-State Owned Government Facility
3. Is the hospital's average patient length of stay less than 25 days?
   - Yes
   - No – To be eligible for incentive payments a hospital's average length of stay must be 25 days or less. Please go back and check your figures before continuing with the data input.
4. Does the hospital have any sanctions pending?
   - Yes
   - No
     Upload supporting documentation
     - Sanctions Details
     - Other
   - The hospital's Medicaid ID is:
     - Enter the TennCare-issued Medicaid ID number

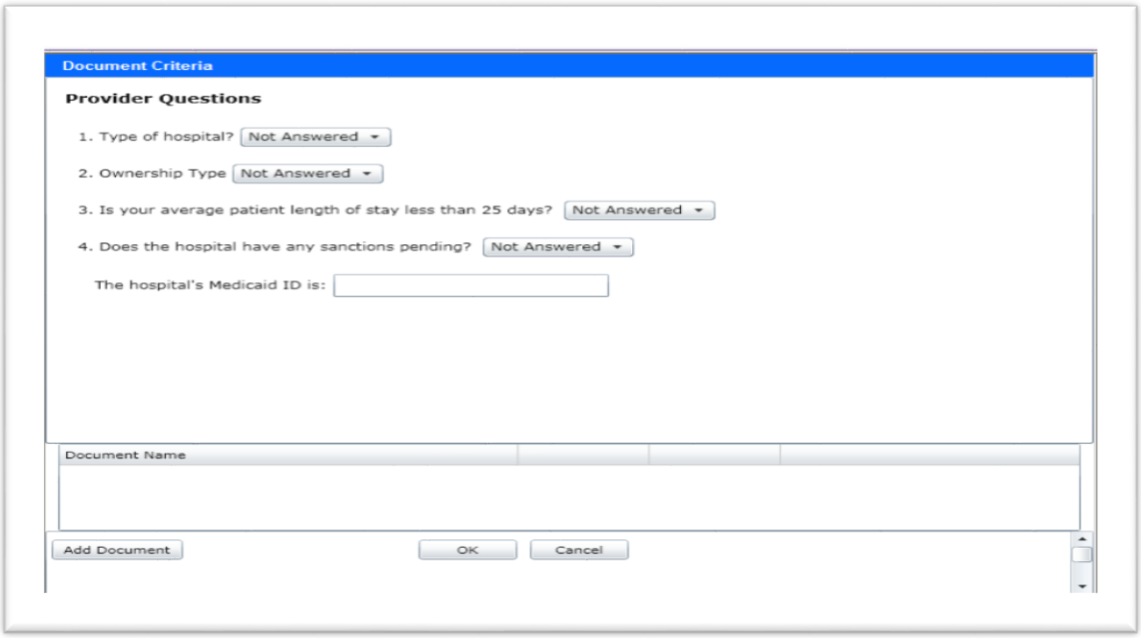


Figure 54 - EH Provider Questions

5.1.2 EHR Questions

Please see Figures 55 and 56.

1. Has the hospital adopted, implemented or upgraded to certified electronic health record (EHR) technology? This information must be provided each year of attestation.
   - Yes
   - No - In order to attest, the hospital must have adopted, implemented or upgraded to certified electronic health record technology. Please see the FAQs for more information.
     - **Note:** After Program Year 1, the EHR Certification Number will not be pre-populated. You must enter the EHR Certification Number. It must match exactly to the CHPL web site.
     - If you have the same system as the previous year, you must still upload documentation as you did the previous year.
     - If you have changed systems or added modules that change your CMS certification number, you must provide the name of your system and/or module(s), version number (if appropriate), and the ONC certification number if you have it.

2. This is the hospital's CMS EHR Certification number:
   - Please verify this number is correct. If this number does not match your records please correct at the CMS R&A web site – a link is available on the left side of the Attestation screen.

3. Name, version, and description of Certified EHR System:
   - Enter the name, version and a brief description of the hospital's Certified EHR System in the text box provided. The text box is limited to 100 characters. If more space is needed please attach a document with additional details. If you obtained modules, we need the name of each module. Should the text box not provide

enough space, please attach a separate document listing each system and/or module(s) by name, version number (if appropriate), and ONC certification number, if you have it.

4. For what type of payment is the hospital applying?
   - AIU (Adopt, Implement, Upgrade)
   - MU (Meaningful Use)
5. Have you attested with Medicare for a meaningful use payment?
   - Yes/No
   - If Yes, What was your Payment Year for the Medicare incentive?
6. Upload EHR documentation.

Providers are required to submit proof of a legal and/or financial obligation showing that they have adopted, implemented, or upgraded to certified EHR technology (CEHRT). Documentation must be submitted **EACH** year in which you attest for an incentive payment. The following list is acceptable documentation of a legal and/or financial obligation.

- The page of an executed contract or lease agreement clearly showing the CEHRT, vendor, and provider, **AND** the executed dated signature page showing both the provider's and vendor's names and signatures.
- If your current contract/lease requires the vendor to provide you with appropriate updates/upgrades to your system to qualify it as CEHRT, executed upgrade agreements for which a cost and timeframe are stated, **AND** identifies your CEHRT.
- A copy of the vendor's invoice clearly identifying your CEHRT, **AND** proof of payment.
- A copy of your purchase order identifying the vendor and CEHRT being acquired, **AND** proof of payment.
- If using one of the free CEHRT, documentation requirements are a signed letter on the vendor's letterhead identifying the provider and CEHRT, **AND** a copy of the User Agreement.

NOT acceptable as documentation:

- A screenshot of CHPL showing the CMS certification number of your CEHRT
- A screenshot of your computer showing your CEHRT
- Requests for Proposals (RFPs) or vendor bids

- For your documentation to be **valid, it must identify** the CEHRT system that you are using. For example, if you are using item 1 above – the executed contract or lease and signature page – if the first page does not identify your CEHRT, then you must include the page(s) which do.
- Other than when a provider is using a free, online CEHRT where a vendor's letter is required, we **DO NOT** accept vendor's letters or other statements as proof of a legal and/or financial obligation for access to a CEHRT system.

- When you are upgrading from one edition of CEHRT, such as from the 2011 Edition to the 2014 Edition, your documentation must clearly show this upgrade occurred.

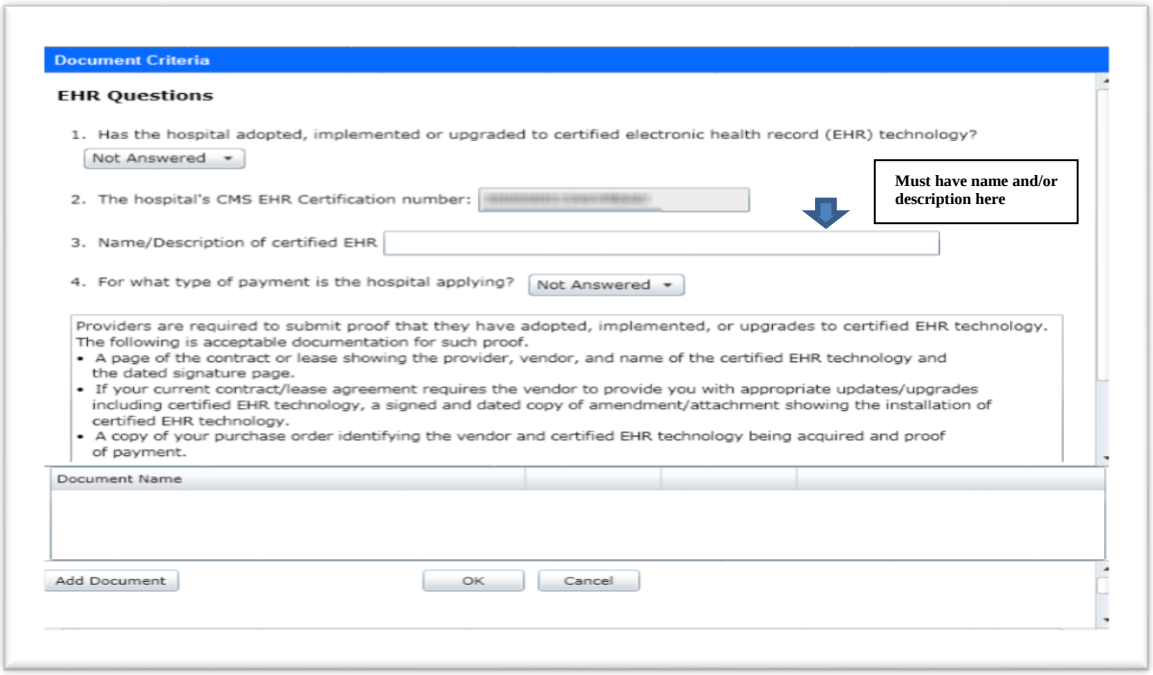


Figure 55 - EH EHR Questions 1

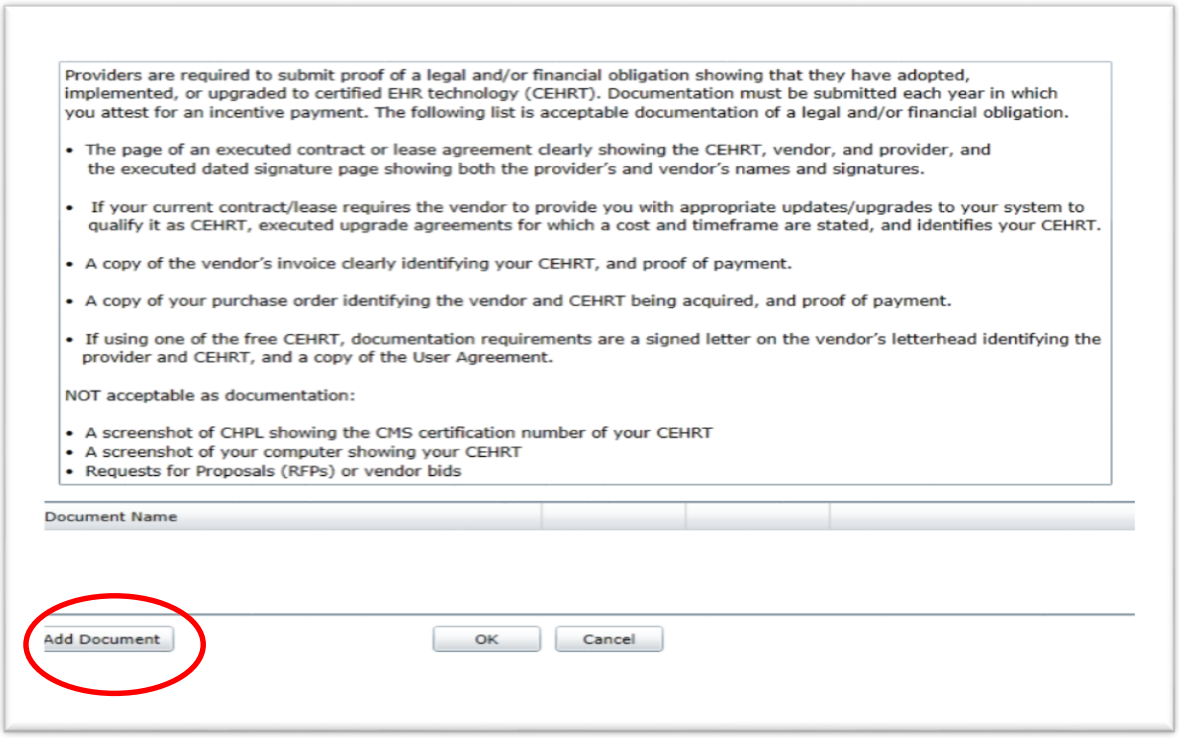


Figure 56 - EH EHR Questions 2

5.1.3 Required Form

Please see Figure 57.

A new Signature Page must be submitted each year and it must be the current version in use. This is now the only Required Form.

➲ The Signature Page must be signed and dated within 90 days of the date you submit your attestation.

A link to the Signature Page is available on the left side of the screen. You must attach this page each year of attestation, or the portal will not let you proceed.

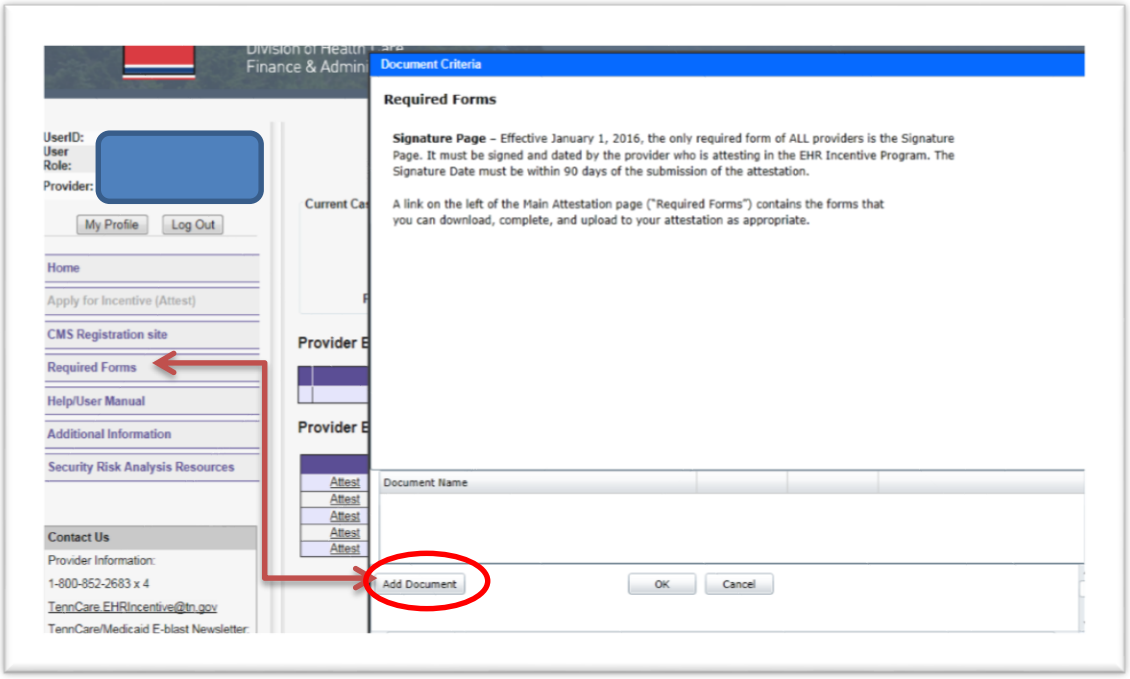


Figure 57 - EH Required Form

5.1.4 Patient Volume Questions

Please see Figures 58 and 59.

- Select the beginning date for the 90-day Patient Volume qualifying period in the preceding fiscal year. (Figure 58) The end date is auto-calculated for you. All eligible hospitals except Children's Hospitals must meet the Medicaid Patient Volume threshold of 10%. (Children's Hospitals do not have this threshold requirement; therefore, these hospitals are not required to complete this section.) **NOTE:** The hospital's 90-day period must be completely within the fiscal year used for attestation. ***ALSO:*** *The 2015 change to Calendar Year attesting for EHs* ***DID NOT*** *change the 90-day period from which your patient encounter must come. This data must still come from the previous Fiscal Year.*
  - Begin Date – MM/DD/YYYY

- End Date – MM/DD/YYYY (auto-calculated)

- What is the total number of patient encounters within the selected 90-day qualifying period?
  - Enter the TOTAL patient encounter count for the selected 90-day qualifying period. This number is also referred to as the Patient Volume denominator.
  - For the purpose of calculating Patient Volume, the total patient encounters is the total population regardless of payment source where:
    - Services rendered to an individual per inpatient discharge; or
    - Services rendered to an individual in an emergency department on any one day

- What is the total number of Medicaid encounters for the selected 90-day qualifying period?
  - Enter the Medicaid encounter count for the 90-day qualifying period. This number is also referred to as the Patient Volume numerator.
  - For the purpose of calculating Medicaid Patient Volume, refer to Section 5.1 above for the definition of what is a Medicaid patient encounter.

- Percentage of patient encounters over the selected 90-day qualifying period that were Medicaid:
  - This percentage is automatically calculated using the numerator and denominator information entered above

- Are any of the hospital's Medicaid patients covered by another state's Medicaid program?
  - Yes – The state, patient count and the hospital's Provider Medicaid Number for each state must be entered, starting with Tennessee (Figure 59)
  - No

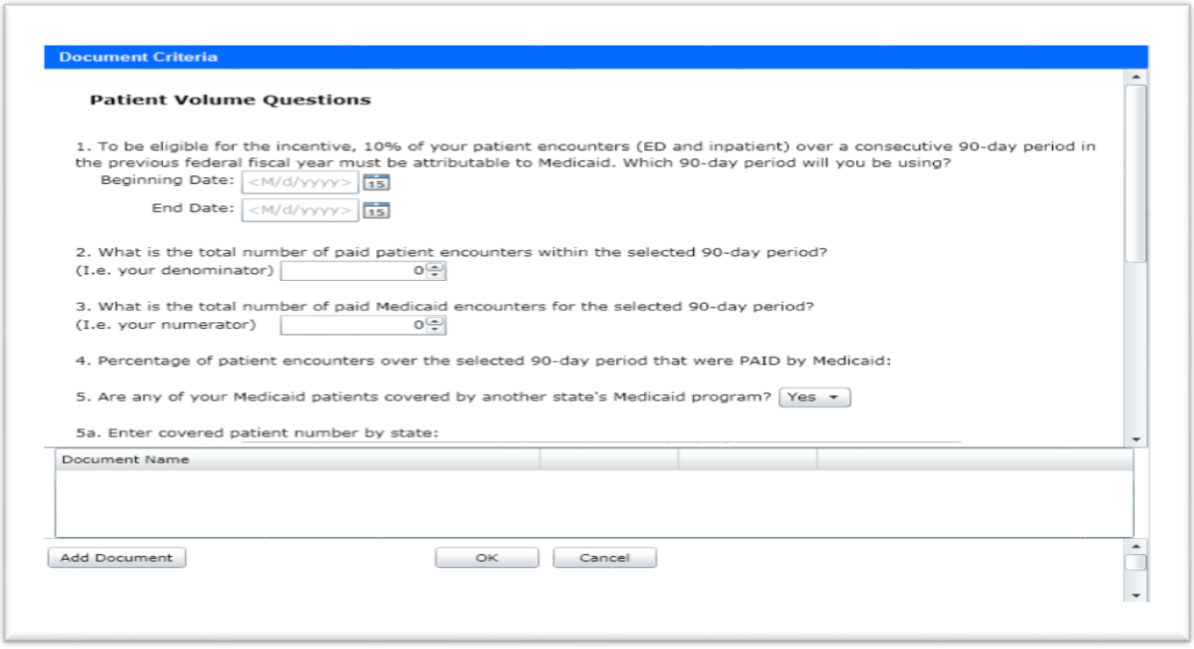


Figure 58 - EH Patient Volume - 1

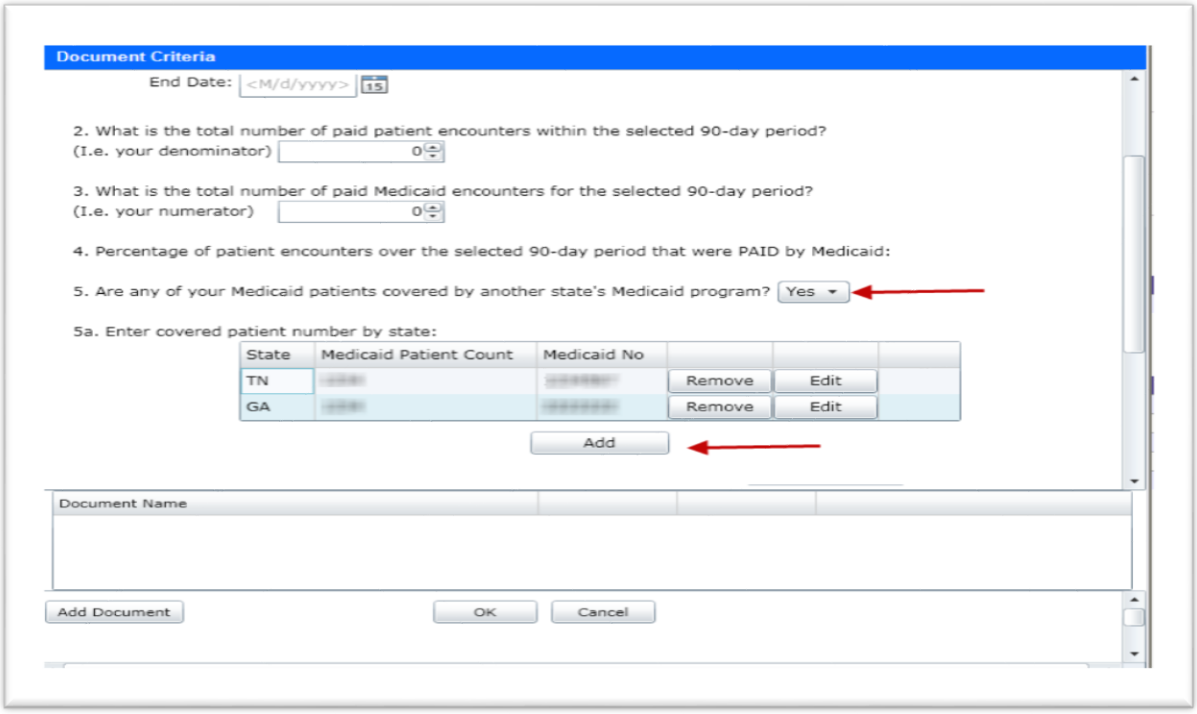


Figure 59 - EH Patient Volume - 2: Other State Coverage

5.1.5 Payment Calculation

Please see Figures 60 and 61.

Data entered in this screen will be used to calculate the total hospital incentive payment amount.

Metric definitions should be consistent with the definitions employed in the JAR or Hospital Cost Reports submitted to CMS.

- Please indicate which definitions you are using:
  - JAR
  - CMS Hospital Cost Report – **If using the CMS Hospital Cost Report,** you are required to upload Worksheets S-3 Part 1, S-10, and C Part 1 for the current and prior years.
- Overall EHR Amount
  - Current Year Discharges
  - Prior Year 1 (Discharges)
  - Prior Year 2 (Discharges)
  - Prior Year 3 (Discharges)
  - Click 'COMPUTE'
- Current Year (New, red arrow)
  Under Average Growth Rate (which is auto-calculated), please indicate in the drop-down box what the Current Year is for 'Current Year Discharges.'

- Medicaid Computation

- Total Medicaid Days – Number of inpatient-bed-days attributable to TennCare Medicaid and Medicaid Managed Care (**Note:** Nursery, Psych, Rehab, and Swing bed days should be excluded from Medicaid days.)
- Total Hospital Charges
- Other Uncompensated Care Charges (aka Charity Charges)
- Total Hospital Days
- Click 'COMPUTE'

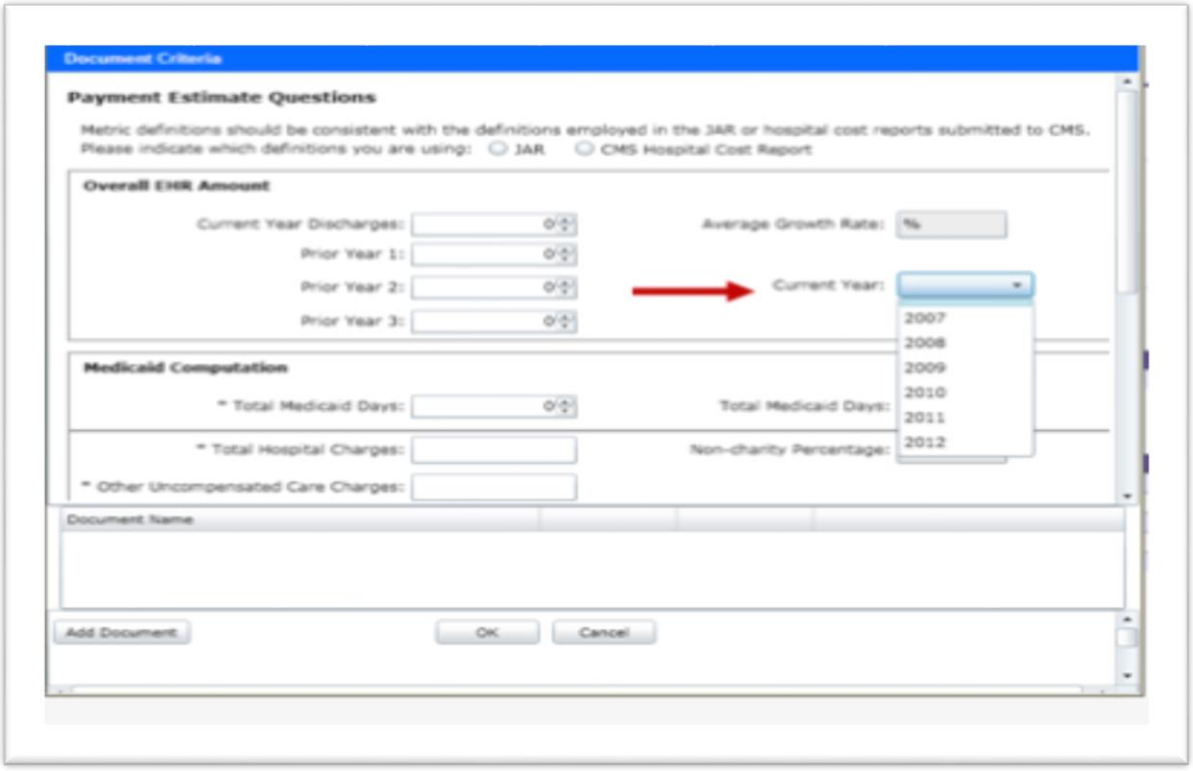


Figure 60 - EH Payment Calculation - 1

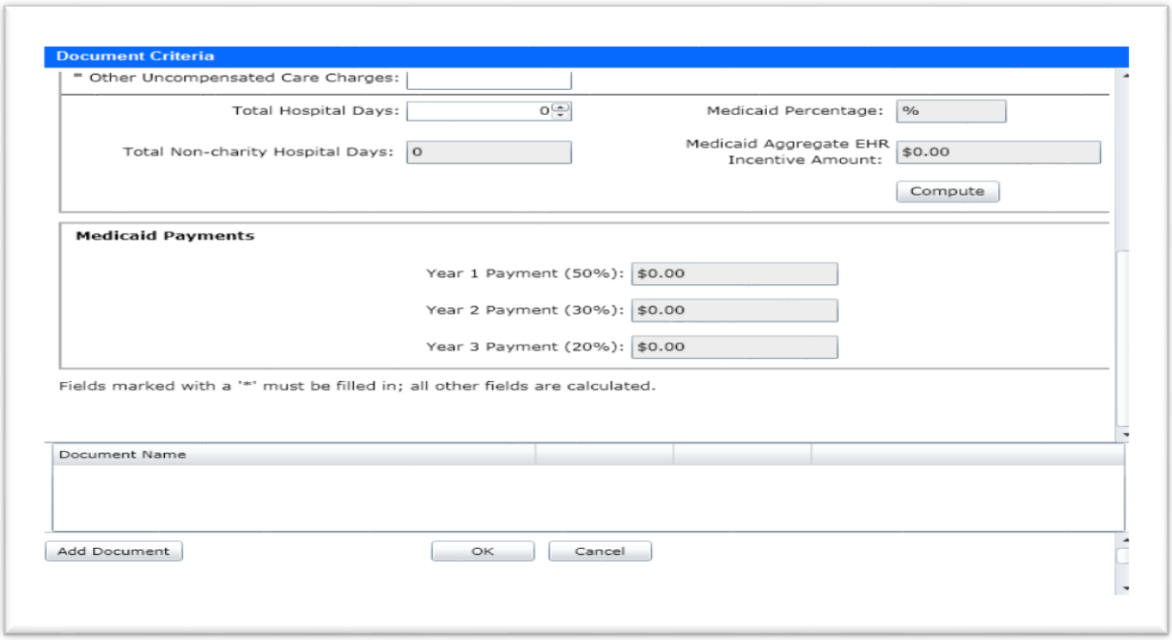


Figure 61 - EH Payment Calculation - 2

The calculations here provide the total amount of the hospital's EHR incentive payment. The incentive payment is made at the rate of 50% for the first year, 30% for the second year, and 20% for the third year, as approved by CMS. However, in order to receive the second and third year payments the hospital must attest to patient volume each year (where appropriate) and furnish new data as required. As previously stated, prior to the third year incentive payment, an audit will be conducted to make sure overpayments or underpayments have not occurred.

Dual eligible hospitals **must attest through** Medicare **first** for the second and third years of attestation. This includes the years after all EHR incentive payments have been made as required by CMS Medicare.

Children's Hospitals always submit their attestations to TennCare.

5.2 Submit Attestation for Review

Once all Attestation links have been completed, the 'Attested?' column on the far right will display 'Yes' for all rows.

When you complete attestation, a button will appear "Submit for Review." After clicking on that button, another box will then appear asking you to either agree or disagree with the statements listed in the box. (Figure 62) Please read the text thoroughly and select the appropriate statement. If you click "I Do Not Agree," your attestation will not be submitted. Clicking on "I Agree" will submit your information to TennCare.

Another box will appear indicating that your information has been successfully submitted. (Figure 63) Click on "Log Out" (upper left hand side) and you are done! If at any time you want to see the status of your attestation, return to the portal, log in, and the latest information will be available to you. (See Section 5.1)

Following submission, the first column will disappear and you will not be able to change the information you entered. If TennCare discovers a problem that requires your assistance to correct, your information will be returned to you and you will then be able to make changes.

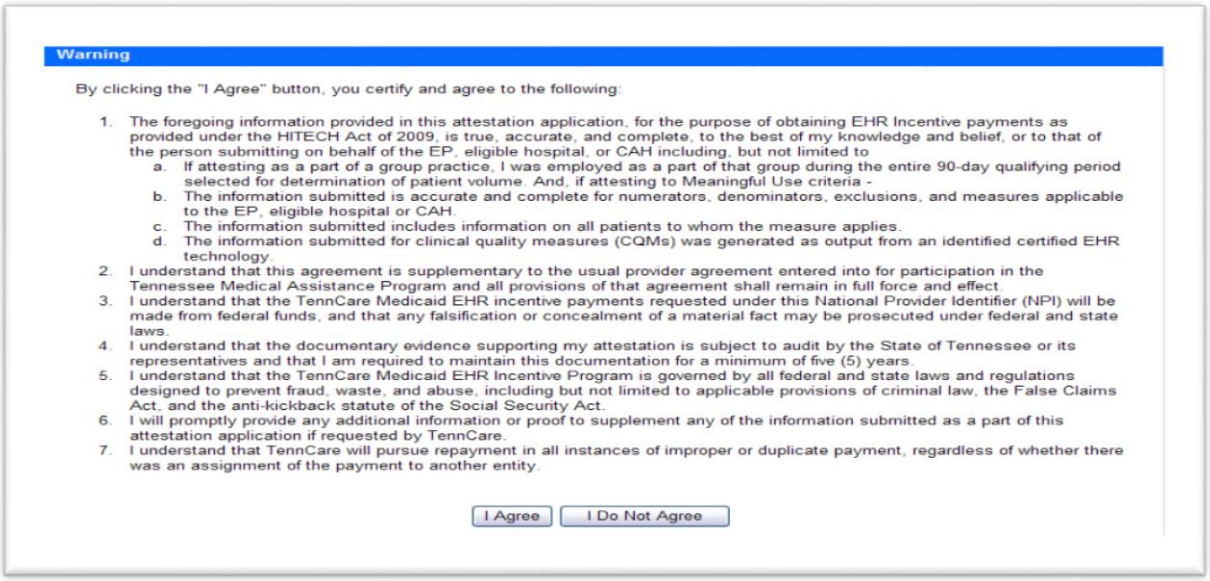


Figure 62 - EH Attestation Submission - 1

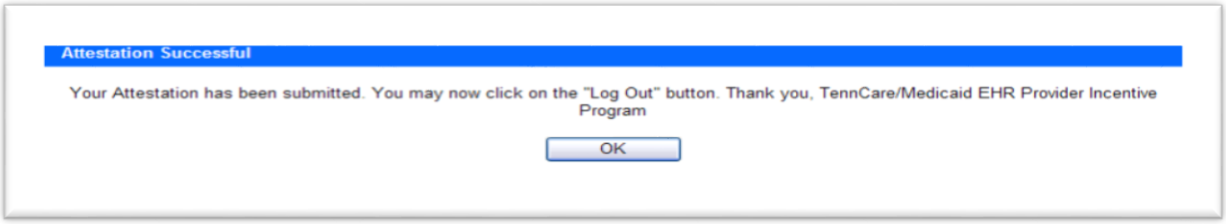


Figure 63 - EH Attestation Submission - 2

5.3 Meaningful Use (MU) Attestation

Note: If you have questions or comments about this section, send an email to EHRMeaningfuluse.TennCare@tn.gov.

Acute Care Hospitals and Critical Access Hospitals (CAHs) must do MU attestation through the Medicare EHR Provider Incentive Program. Once CMS has approved the EH as being a meaningful user, CMS will notify TennCare. TennCare will then send the EH an email instructing the EH to go to the TennCare PIPP portal to attest for the Medicaid EHR Incentive payment. Therefore, this section does not apply to these hospitals.

Medicaid-only and Children's Hospitals must attest to MU through the TennCare Medicaid EHR Incentive Program. Please follow the instruction presented in this section. Any questions may be sent to the email address above.

This section provides instruction for Eligible Hospitals (EHs) attesting to MU (Payment Years 2 – 3). Attestation for MU begins with answering the same questions as in Payment Year 1 and continues through the meaningful use criteria.

See Section 5.1 Eligible Hospital (EH) Provider Attestation above for a description of the home page. However, under "Provider EHR Criteria" you will notice two new, required pages have been added. (Figure 64) They will only appear for MU Attestation. These pages are:

- Meaningful Use Questions
- Meaningful Use Clinical Quality Measures

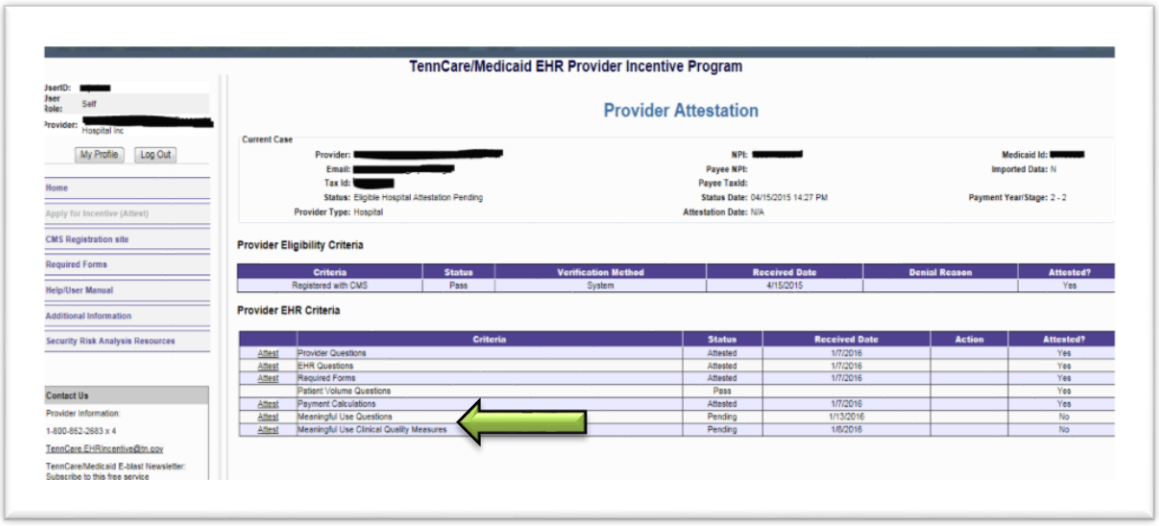


Figure 64 - EH Provider Attestation

5.3.1 Initial & Subsequent Attestations

As shown in the figure above, EHs must answer the first four screens listed **each** year in which they attest. These screens are

- Provider Questions (See Section 5.1.1)
- EHR Questions (See Section 5.1.2)
- Required Forms (See Section 5.1.3)
- Patient Volume (See Section 5.1.4)

The Payment Calculations screen (Section 5.1.5) is **only** completed in the first year of attestation.

As previously stated, for an MU Attestation, the two additional screens must be completed for the second and third year attestations.

5.3.2 Meaningful Use Questions

All EHs and CAHs are required to attest to a single set of 9 Modified Stage 2 MU Objectives, including one consolidated public health reporting objective. This replaces the Core and Menu structure of previous stages. In 2015, there are some alternate

exclusions and specifications available to accommodate providers that were previously scheduled to demonstrate Stage 1. In addition to the MU questions, this screen will allow the selection of the EHR Reporting Period and present a short series of General Questions. To begin attesting for the MU questions, click the 'Attest' link next to MU questions on the provider attestation page (See Figure 64). Figure 65 is a screenshot of the first page of the MU questions.

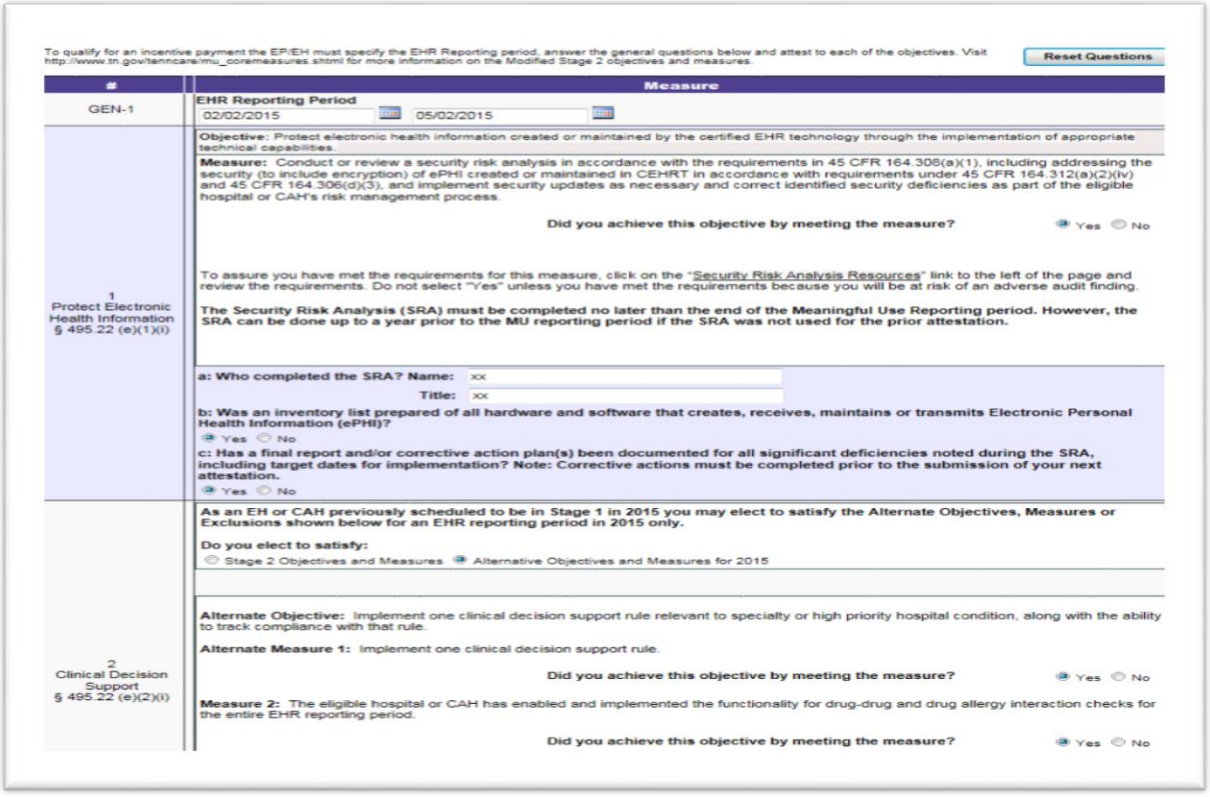


Figure 65 - EH MU Question Screen

5.3.2.1 EHR MU Reporting Period

5.3.2.1 Selection of an EHR MU Reporting Period

- Select the beginning date for the EHR MU Reporting Period. The date can be entered (MM/DD/YYYY) or selected from the drop-down calendar (Figure 66). The end date is automatically calculated for you. The required EHR MU Reporting Period is subject to the following rules:
  - **Payment Year 1:** The EHR MU reporting period is any consecutive 90 days within the calendar year. **In 2015 only,** the reporting period for EHs/CAHs is any consecutive 90-days within the period beginning October 1, 2014-December 31, 2015. *NOTE: It is likely that all Medicaid-only EHs will attest to AIU for the first payment year. Thus, the EHR reporting period will not be used, as the hospital will not be attesting for MU.*
  - **Payment Year 2:** For the first year of MU, the EHR MU reporting period is any consecutive 90-day period within the calendar year. ***In 2015 only**, the reporting period for EHs/CAHs is any consecutive 90-day period within the period*

beginning October 1, 2014-December 31, 2015. ***NOTE:*** EHs may demonstrate AIU for Payment Year 1 and MU for Payment Year 2. Therefore, the EHR reporting period will be any 90 consecutive days in the current calendar year.

- **Subsequent Payment Years:** The EHR reporting period is the calendar year.

Example: The provider is attesting for Payment Year 3. The provider received a payment for year 2 in 2015 with an EHR reporting period of January 1, 2015-March 30, 2015. The next period to which the provider can attest is the entire calendar year of 2016, which makes the earliest the provider can attest for year 3 is January 1, 2017. In 2015 only, the reporting period is between October 1, 2014-December 31, 2015.

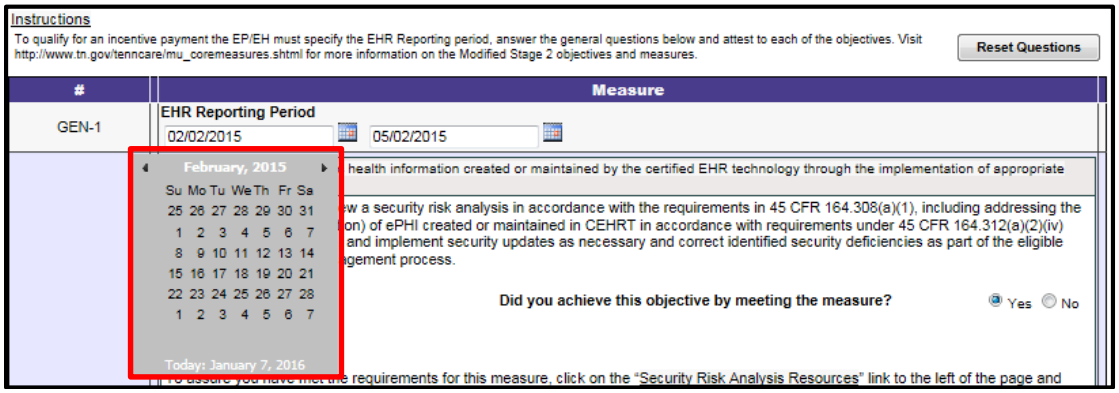


Figure 66 - Selection of EH MU Reporting Period

5.3.3 General Questions

The meaningful use questions screen begins with a short series of general questions that are intended to ensure the EP can meet the thresholds for MU attestation as well as provide TennCare with criteria to perform analysis of aggregated MU objectives and clinical quality measures.

- **General Question 1** – Does not apply to Eligible Hospitals and will not be on the screen
- **General Question 2** – Eligible hospitals must attest that at least 80% of unique patients must have their data in the certified EHR during the EHR reporting period. Enter a numerator and denominator.
  - Numerator: Number of patients in the denominator with data maintained in a certified EHR during the EHR reporting period
  - Denominator: Number of unique patients seen by the EP during the EHR reporting period
- **General Question 3** (Figure 67) – To aid TennCare in the analysis of MU data on a regional basis, TennCare is requiring the eligible hospital to enter the primary county in which they operate. Select the county from the drop-down box provided.

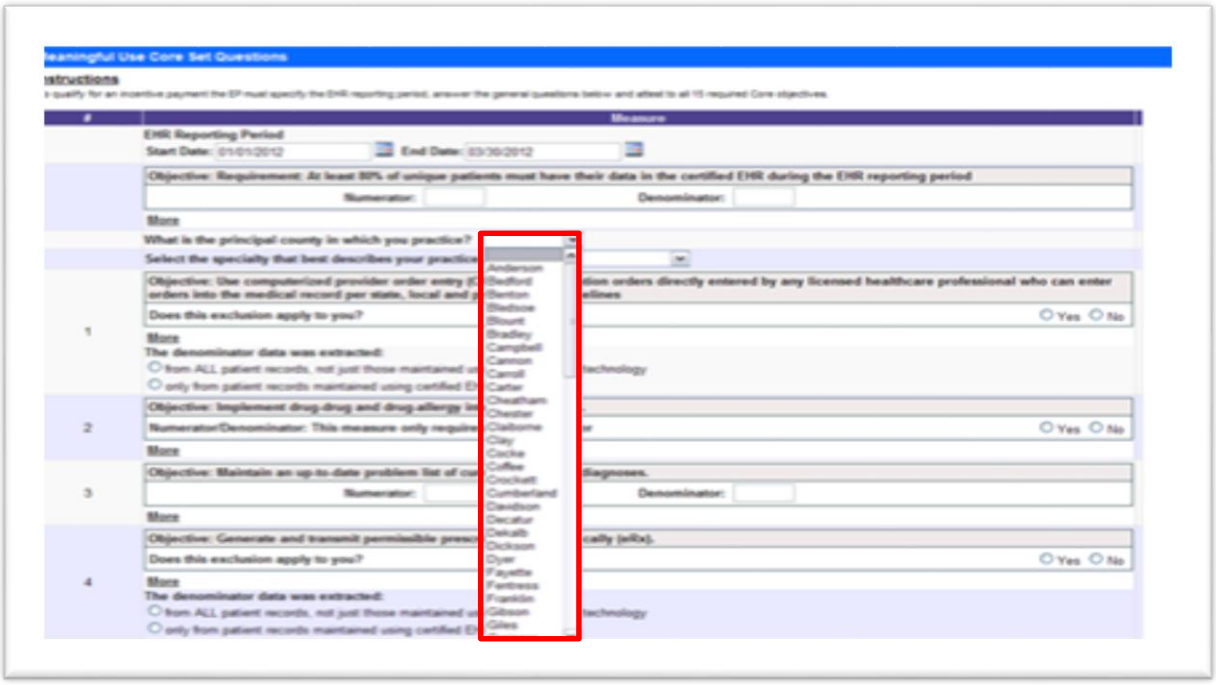


Figure 67 - Selection of Principal County

- **General Question 4** – Does not apply to Eligible Hospitals and will not be shown on the screen

5.3.4 Meaningful Use Objectives/Measures

The EH must attest to all 9 MU objectives including 1 consolidated public health reporting objective. Attestation for most objectives is accomplished by entering a numerator, denominator, and exclusion information. Certain measures do not require a numerator and denominator. Instead, these measures require a Yes/No answer, and are marked as such. Measures that allow exclusions are indicated, and claiming the exclusion is attesting to that measure. Providers may be also asked specific details regarding a particular measure. All fields are required to submit the attestation for review. Providers must enter additional information to some of the MU questions.

For the 2015 EHR reporting period alternate exclusions and specifications for certain objectives and measures are available for providers that were previously scheduled to be in Stage 1. Upon attestation, these providers will be offered the option to attest to the Modified Stage 2 objective and measure, *and* the option to attest to the alternate specification or claim the alternate exclusion, if available.

5.3.4.1 Source for Denominator Data

Some questions require the hospital to attest to whether the data for the denominator was obtained from ALL patient records or just those that are maintained using EHR technology. The provider must select the radio button, which indicates the source of the denominator. (Figure 68)

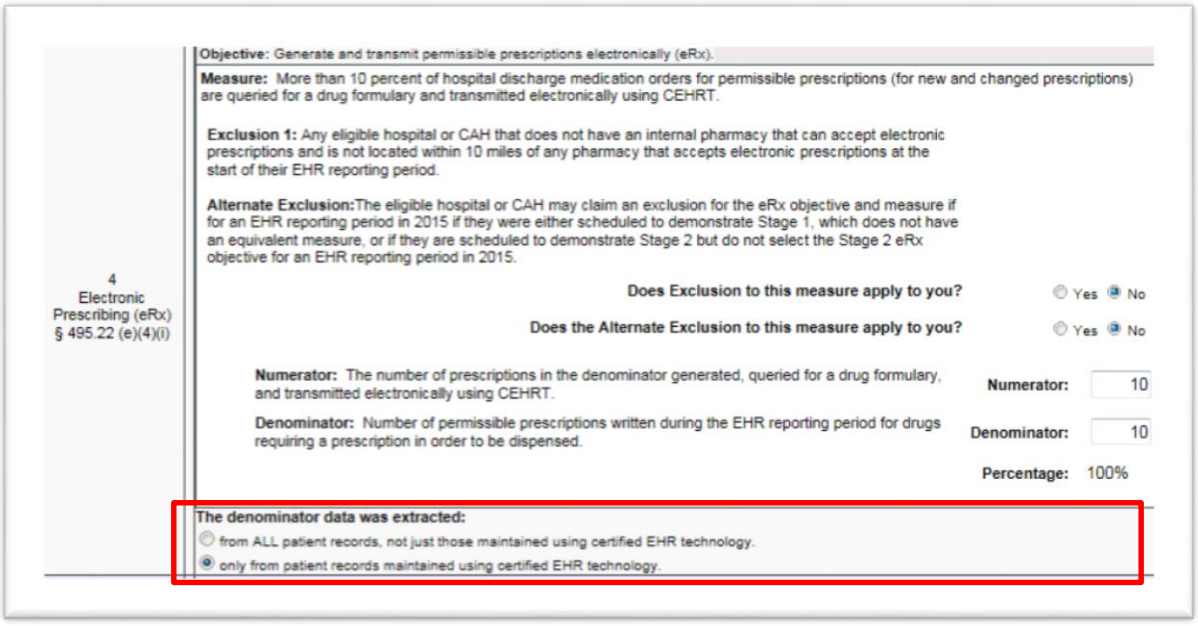


Figure 68 - Select Source for Dominator Data

5.3.4.2 Additional Screen Functions

At the bottom of the Core Set question screen are buttons that provide additional functionality. (Figure 69)

- **Add Document** – The system provides the ability for the provider to submit additional documents to support their attestation. Submission of additional documentation is not required but doing so may speed up the review and approval process for receiving incentive payments.
- **OK** – Clicking the OK button completes this attestation screen. The system will automatically check to ensure that all objectives and measures are attested to and alert the provider of any missed items. Once all deficiencies are corrected clicking OK will save all answers and return to the Provider Attestation screen.
- **Save and Exit** – Clicking the save and exit button allows the provider to save their work and return to the attestation later. The provider will be returned to the Provider Attestation page.
- **Cancel** – Clicking cancel will return the provider to the Provider Attestation page. NOTE: Any data entered in the current session will **NOT** be saved.

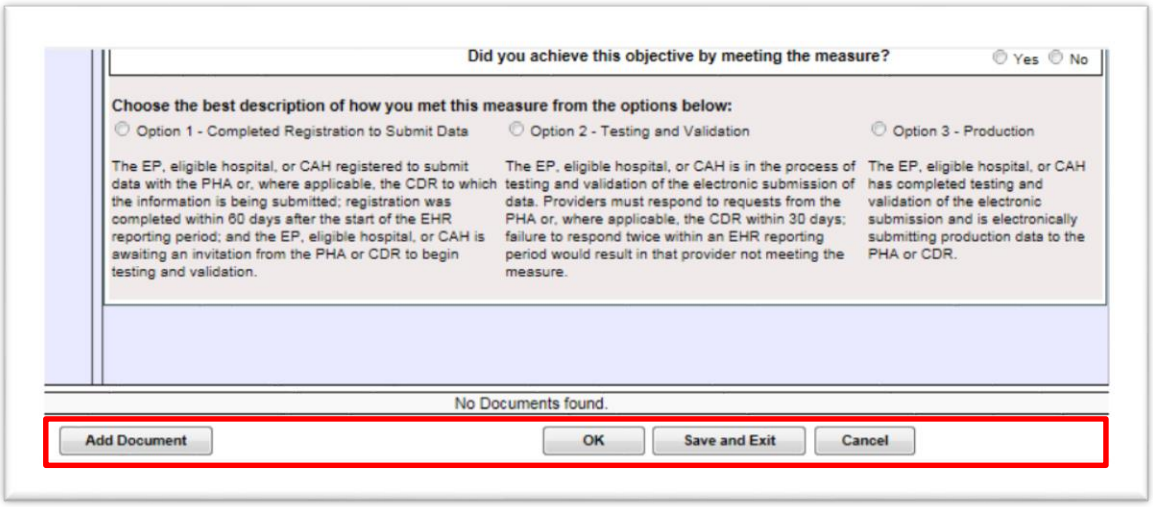


Figure 69 - Additional Screen Functions

5.3.5 EH Clinical Quality Measures (CQMs)

To qualify for the incentive payment, EHs must attest to 16 of 29 CQMs. Selected CQMs must cover at least 3 of the National Quality Strategy domains. (Figure 70) Numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology. Functionality for Add Document, OK, Save and Exit, and Cancel are the same as the Core Set screen. See Section 5.3.4 for details.

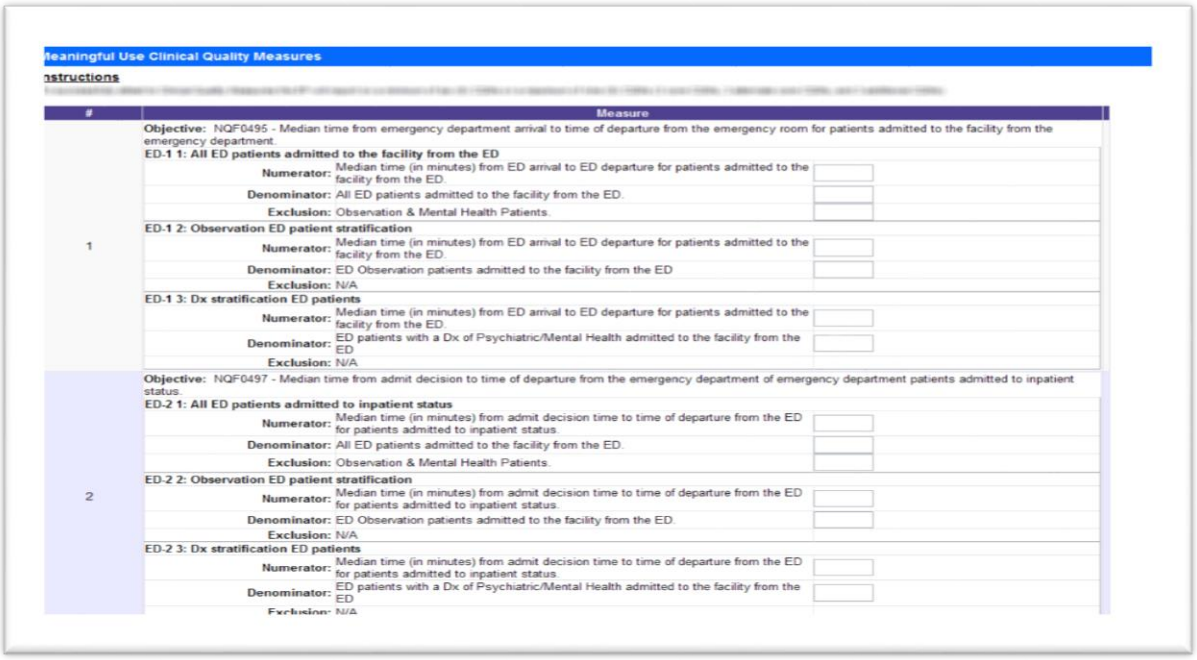


Figure 70 - EH Clinical Quality Measures

5.4 Submit Attestation for Review

Once you have completed the MU attestation screens, see Section 5.2 above on how to submit your attestation for TennCare to review. Once eligibility, EHR certification and patient volume are verified, the attestation will be placed in Quality Review status. All program year three hospitals will remain in Quality Review status until the payment year 1 and 2 audits have been completed. A standard set of criteria will be used to verify all MU Measures and CQMs. Your attestation may be returned to you with a letter stating outstanding issues, questions or requesting supporting documentation that must be resolved in order to receive payment. Address these questions and re-submit your attestation as soon as possible. If you need technical assistance, send a request via the ehrmeaningfuluse.tenncare@tn.gov mailbox.

6. Appeals (EP and EH)

If your EHR Incentive Payment Attestation is denied, or you do not agree with the payment amount, you have the right to submit an appeal. You also have the right to appeal a payment adjustment resulting from a post-payment audit. An appeal must be submitted within 35 days of the date of TennCare's notice of action.

When you request an appeal, it will be set for a hearing if it cannot be resolved prior to submission to the Bureau's Office of General Counsel (OGC). You will receive a Notice of Hearing from OGC; the matter will be heard before an Administrative Law Judge (ALJ); and an Initial Order (IO) will be issued. The IO will become the Final Order (FO) if it is not appealed; if the IO is appealed to the Commissioner's Designee, an FO will be issued following a hearing on the appeal of the IO.

NOTE: There is nothing to appeal if we have returned your attestation because it does not meet the necessary requirements. As stated in the Return Notice, we are giving you a chance to correct and resubmit your attestation without us denying it.

6.1 Access Appeals Page

If you are not already logged into the system, you will need to log in to submit an appeal.

From the Home Page, navigate to the 'Appeals' link found on the left side of the screen. (Figure 71)

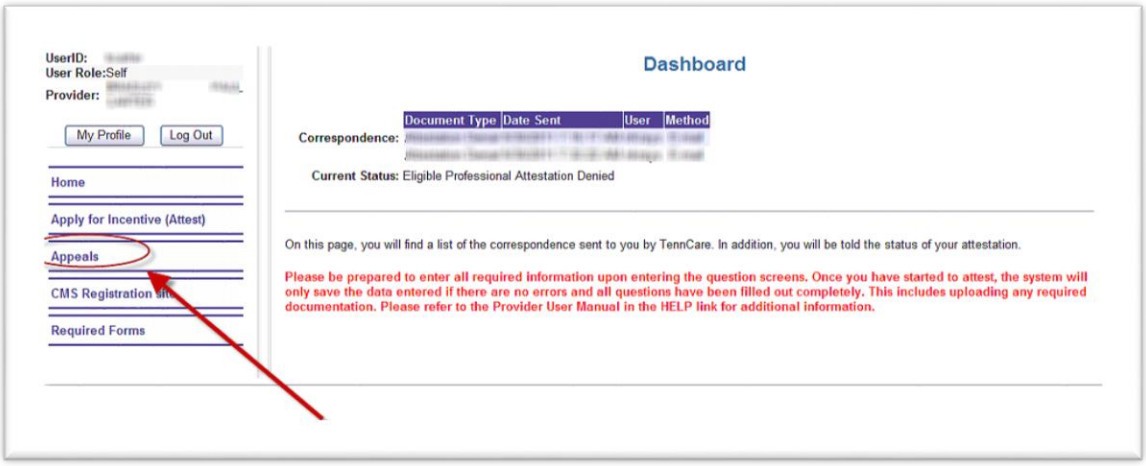


Figure 71 - Appeals Link

On the top portion of your screen, you will see your provider data including the Denial Date, Denial Reason, and Appeals Activity Log. Below your information, you will find the instructions on how to submit your appeal. (Figure 72) Note: this is actually a shot of how an appeal appears when received by TennCare.

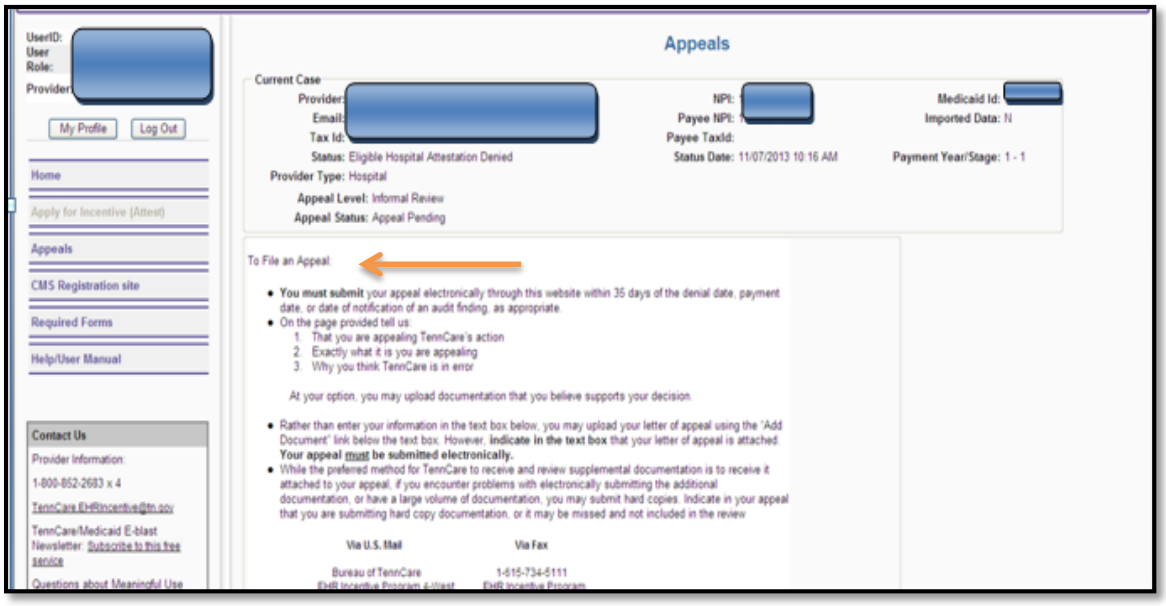


Figure 72 - Appeals Screen

On-screen instructions on how to file an appeal:

To File an Appeal (orange arrow):

- **You must submit** your appeal electronically through this website within 35 days of the Denial or Payment Complete date.
- On the page provided tell us:
  1. That you are appealing TennCare's action;
  2. Exactly what it is you are appealing; and
  3. Why you think TennCare is in error.
  4. You may upload documentation that you believe supports your position.
- Rather than enter your information in the text box provided, you may upload your letter of appeal using the supporting documents link. However, **your appeal must be submitted electronically.**
- While the fastest way for TennCare to review supplemental documentation is to receive it electronically, if you encounter problems with an electronic submission, or have a large volume of documentation, you may submit hard copies:

Via U.S. Mail	**Via Fax**
Bureau of TennCare	1-615-734-5111
EHR Incentive Program 4-West	EHR Incentive Program
ATTN: Provider Appeals	ATTN: Provider Appeals
310 Great Circle Road	
Nashville, TN 37243	

On the lower part of this screen, you will tell us what type of appeal you are filing (red arrow). (Figure 73) There are three types of appeals accepted by TennCare.

- Attestation Denial
- Payment Amount
- Audit Finding

The example here is “Attestation Denial.”

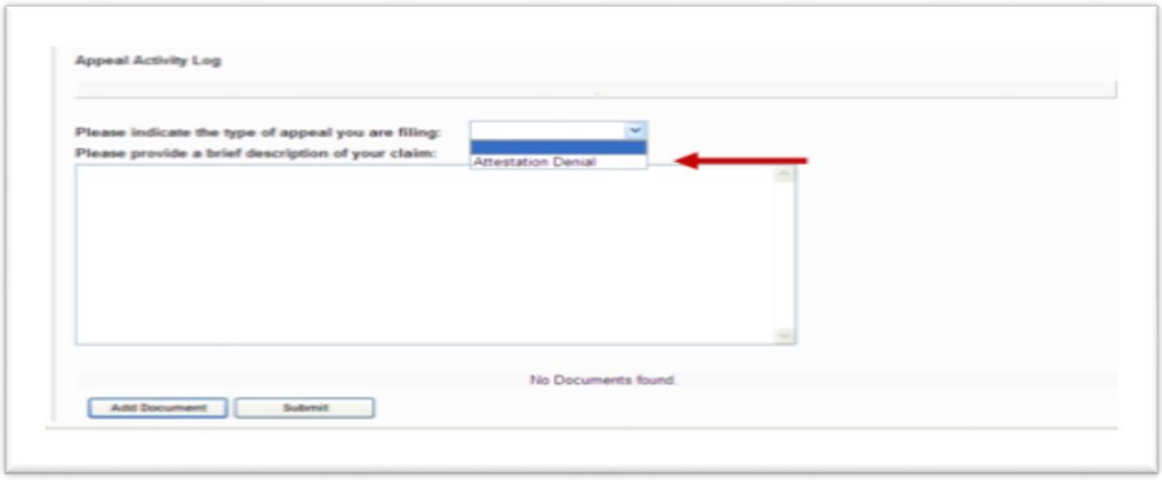


Figure 73 - Type of Appeal

6.2 Submitting an Appeal

The large box (large arrow) in Figure 74 is for the description of your appeal. Explain, as concisely as possible, what is you are appealing. Tell us why you think TennCare is wrong in its decision. (**NOTE to EPs on payment amounts:** The amount of the EP EHR Incentive Payment is fixed by statute. There are no reductions in payments – other than the reduced amount received by pediatricians attesting with a Patient Volume equal to or greater than 20% and less than 30%.)

As stated in the instructions, you may choose to submit your appeal written out instead of typing it in this box. However, **it must be uploaded** to the Appeals screen and submitted electronically. To upload your written appeal, use the “Add Document” function (blue arrow).

- Upload any supporting documentation – if the additional information you wish to submit is substantive or exceeds the size allowable for an email, you may submit this documentation through the US Mail or by fax as indicated on the screen. The preferred method of submitting documentation is by utilizing the “Add Document” (blue arrow) function on this page. It is imperative that you state in your appeal that you are submitting documentation via an alternative method; otherwise, it may be overlooked. In your documentation, state that this is to be included in the review of your appeal and the date the appeal was submitted.
- Click Submit (green arrow)

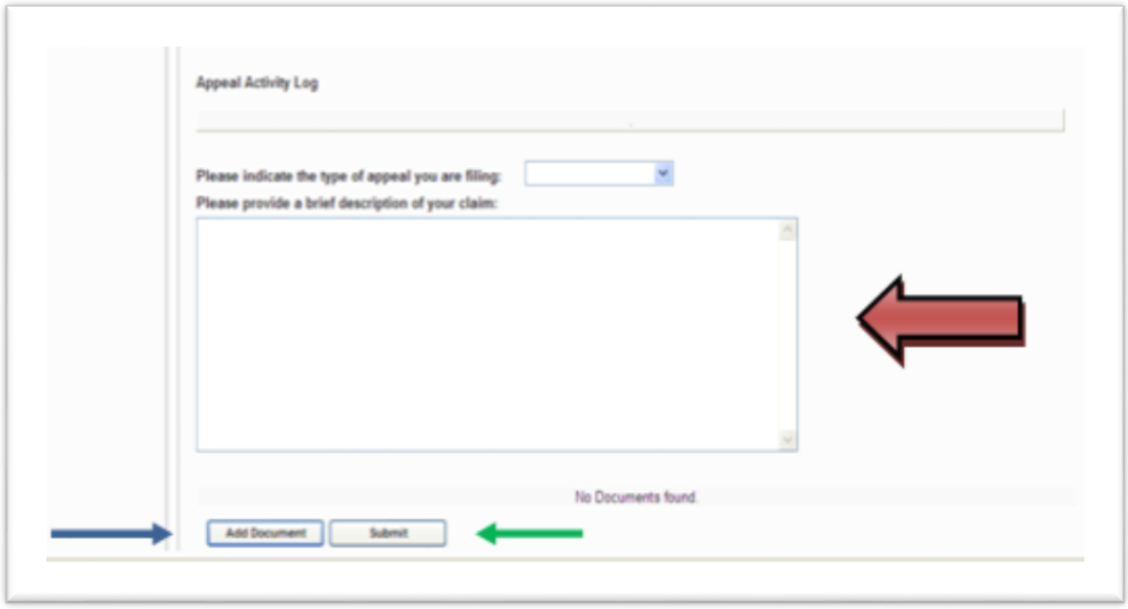


Figure 74 - Description of Appeal

7. Resources

In addition to this PIPP User Manual, there is information available to you about the EHR Provider Incentive Program from a number of sources.

7.1 Centers for Medicare and Medicaid Services (CMS)

For an overall view of the EHR Provider Incentive Program, you can go to the CMS web site here. This is also the site where you register to participate in the EHR Incentive Program, whether you attest through the Medicare Program or Medicaid. (Figure 75)

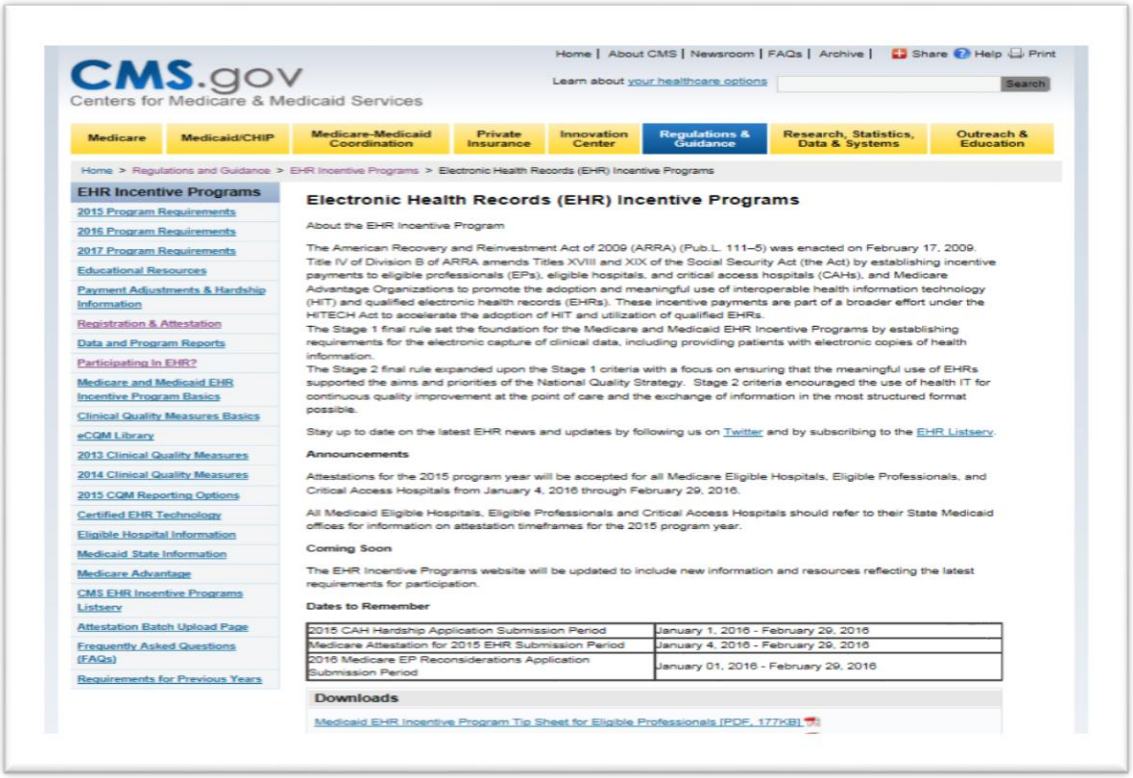


Figure 75 – CMS EHR Incentive Web Site

If you have questions or problems with the CMS Registration & Attestation System (R&A) web site, call the CMS Help Desk at 1-888-734-6433.

Keep in mind that this site contains the foundation of the EHR Incentive Program. It **focuses** on the Medicare incentive program, and gives general information about attesting through Medicaid. **For specific information about the TennCare Medicaid EHR Provider Incentive Program,** you will need to visit our web site, in addition to this manual. Naturally, any conflict between the information provided by CMS and TennCare, CMS will take precedent.

7.2 Bureau of TennCare

7.2.1 Web Site

The Bureau's EHR web site (Figure 76) can be found here. Available on our web site, as shown below, are links to various topics.

- EHR Incentive Overview
- E-Blast Newsletters
- How to Register & Attest
- Meaningful Use Overview
- Program Integrity & Audit
- Resources, which includes
  - Acronyms
  - Contact Us
  - FAQs
  - PowerPoint Presentations

Each of these links will provide you with additional information on each particular topic.

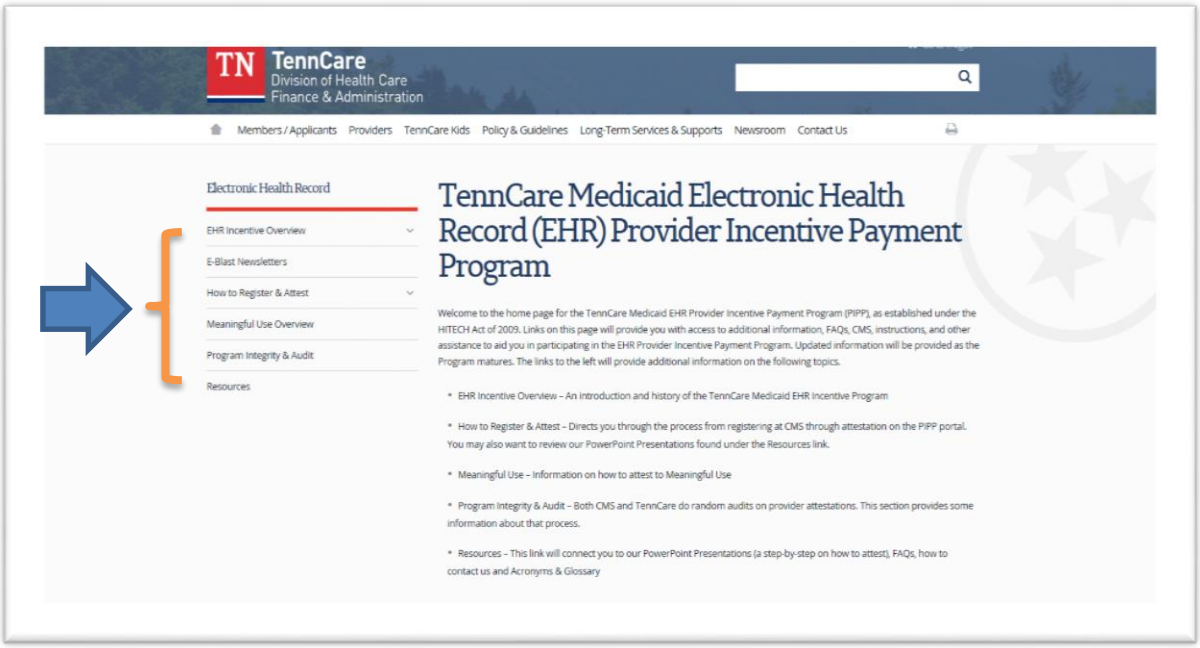


Figure 76 - TennCare EHR Incentive Home Page

Figure 77 shows the lower portion of the EHR Home Page. There you will find links to a weekly update of number of providers and total amounts paid, information about the Medicare payment adjustments, and a link to subscribe to our newsletter and back issues as well.

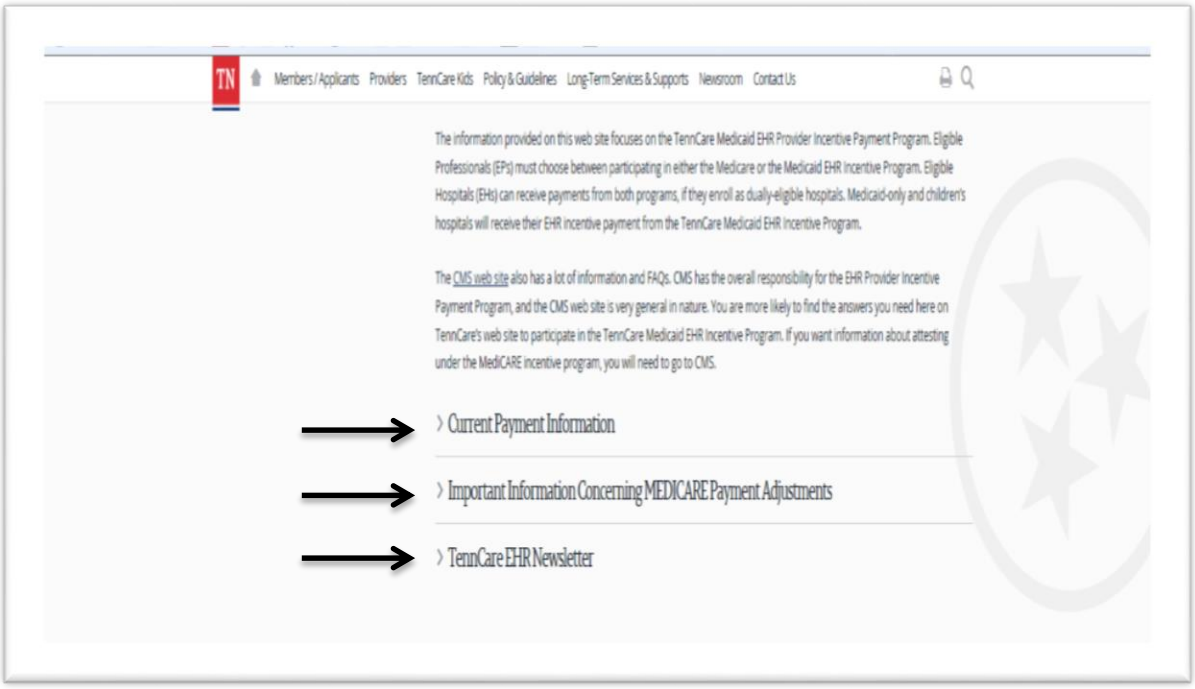


Figure 77 - TennCare EHR Incentive Home Page

7.2.2 Still Have Questions

- Whenever emailing TennCare about a specific provider, **please include the provider's name and NPI**.

- For questions about Meaningful Use attestation, including when your status is Quality Review or Quality Pending, you can send an email to EHRMeaningfuluse.TennCare@tn.gov.

- All other questions about the EHR Incentive Program may be emailed to TennCare.EHRIncentive@th.gov.

- Some problems we encounter involve your registration and enrollment in the TennCare Program as a provider. If you have questions about your status as a TennCare provider, please email Provider.Registration@tn.gov.

7.3 Office of the National Coordinator for Health Information Technology (ONC)

This office is responsible for verifying that the EHR systems and modules meet the federal requirements to be considered "certified EHR technology" (CEHRT) for the purposes of the EHR Incentive Program.

The list of certified products is referred to as the Certified Health IT Product List (CHPL – pronounced 'chapel'). (Figure 78) If you do not have the CMS Certification Number for your system or module(s), this is where you must go to obtain it. Your vendor may

supply you with this number, but it is your responsibility to obtain the number and report it to TennCare.

http://oncchpl.force.com/ehrcert

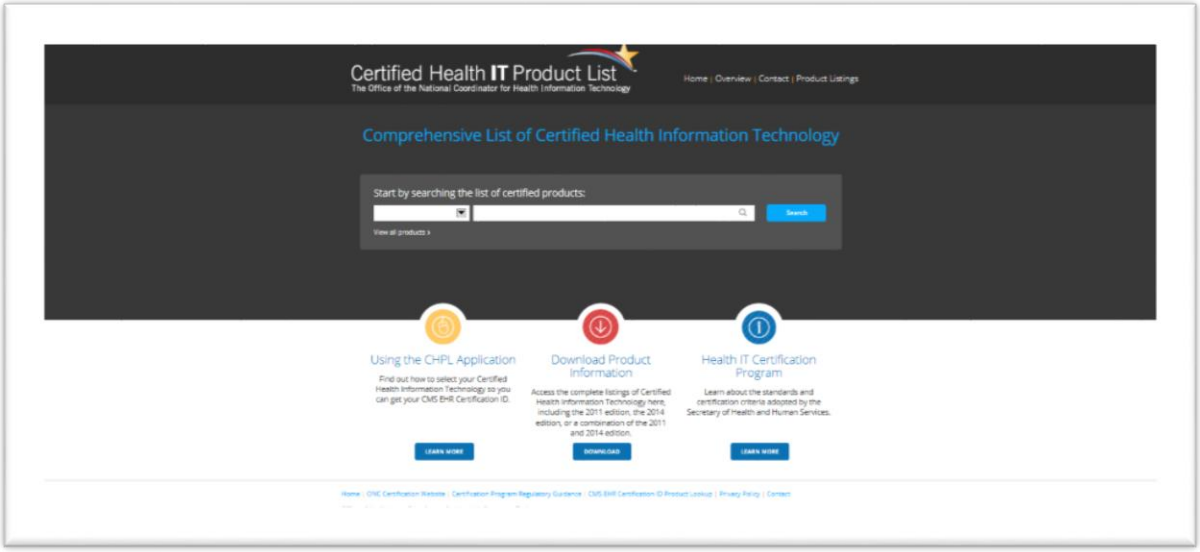


Figure 78 – CHPL Web Site

Note: When registering at the CMS R&A web site, the process indicates that supplying the CMS Certification Number of your CEHRT is optional. When registering to participate in the TennCare Medicaid EHR Provider Incentive Program it is **MANDATORY** that you enter the CMS Certification Number at this point. You will not be allowed to attest until this number is present in your registration information received from CMS.